

“WHY WOULD YOU NOT WANT TO ACCEPT WHAT GOD HAS GIVEN YOU?”: SOUTH ASIAN WOMEN’S DISCOURSE ON TERMINATION OF PREGNANCY

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A thesis submitted in partial fulfilment of
the requirements of the University of
Lincoln for the degree of Doctor of
Clinical Psychology

2012

Thesis Abstract

Introduction: There are mixed findings about whether termination of pregnancy (ToP) is a significant life event that may trigger a negative psychological reaction in vulnerable women, or whether ToP is a minor life event (or not considered a life event) with minimal or temporary detrimental effects. The quality of studies exploring these issues varies substantially in terms of sample size, sample selection and validity of measures. Existing studies do not consider the role of discourse in the construction of ToP. This is significant because discourse has the potential to influence meaning, practices, and reported psychological distress.

Objectives: This study employed a qualitative methodology to explore how discourse operates through power to produce a particular 'truth' of ToP and the effects of this.

Design: A Foucauldian Discourse Analysis approach was taken using Berg's (2009) model to analyse the data obtained from the interviews.

Method: Initially, a document analysis was performed where literature about ToP, produced by health organisations in the UK, was collected in order to contextualise health/legislative discourse. Next, discourse was collected from interviews conducted with six South Asian women recruited from community centres in Nottinghamshire and South Yorkshire.

Results: Religious and cultural discourses were perceived to have validity and worth and produced effects- discursively and through practice which influenced how women understood, experienced, and responded to ToP. The discourses identified linked together using 'common-sense' ideas to produce a discourse of ToP.

Discussion: The findings illustrate that taken for granted sets of ideas about who and what exists in the world help to impose bounds beyond which it is often very hard to reason and behave. When particular discourse becomes understood as common sense and 'true', these set limits to the cultural know-how of a particular social group. The clinical implications and the limitations of this study are considered and suggestions for future research are made.

Key words: ToP, abortion, ethnicity, religion, culture, discourse, Foucault

Acknowledgements

I would like to say thank you to my field supervisor Saima Masud and research tutor Roshan das Nair for their regular guidance and supervision.

I would also like to say thank you to everyone who took time to read drafts of my work, and family and friends who have supported me through this process.

Finally, I would also like to thank all the participants who offered their time to take part in the research.

Statement of Contribution

Detailed below is the relevant parties involvement in each stage of the research.

1. Project design: Rajea Begum (with supervision from Roshan das Nair and Saima Masud)
2. Applying for ethical approval: Rajea Begum
3. Writing the literature review: Rajea Begum (with supervision from Roshan das Nair and Saima Masud)
4. Recruiting participants: Three community centres disseminated information about the study to potential participants.
5. Data collection: Rajea Begum
6. Transcription: Rajea Begum
7. Analysis: Rajea Begum (with supervision from Saima Masud)
8. Write up: Rajea Begum (with supervision from Roshan das Nair and Saima Masud)

Table of Contents

Thesis Title Page	Page 1
Thesis Abstract	Page 2
Acknowledgements	Page 3
Statement of contribution	Page 4
Contents Page	Pages 5-6
 SYSTEMATIC REVIEW	 Page 7- 54
Abstract	Page 8
Introduction	Pages 9-15
Methods	Pages 16-25
Results	Pages 25-44
Discussion	Pages 44-47
Conclusion	Page 48
Appendix 1- Electronic search strategies	Pages 49
References	Pages 50-54
 JOURNAL PAPER	 Pages 55- 94
Journal Abstract	Page 57
Introduction	Pages 58-64
Method	Pages 64-66
Document Analysis	Page 66-67
Analytic framework	Pages 67-68
Analysis and Discussion	Pages 69-90
References	Pages 90-94
 EXTENDED PAPER	 Pages 95-199
Extended Background	Pages 96-113
Extended Methodology, Methods and Document Analysis	Pages 113-129

Extended Analysis and Discussion	Pages 130-177
General Discussion and Reflections	Pages 177-190
References	Pages 190-199
 Appendices	
Appendix A – six major tendencies in Islam (Ramadan, 2004)	Pages 200-203
Appendix B – ethical approval correspondence	Pages 204-209
Appendix C – letter to organisations	Pages 210-211
Appendix D – participant information sheets	Pages 212-215
Appendix E – posters displayed in organisations	Page 216
Appendix F – demographic data sheet	Pages 217-218
Appendix G – consent form	Pages 219-221
Appendix H – interview schedule protocol	Pages 222-224
Appendix I – Jeffersonian rotation system	Page 225

Section One: Systematic Review

What factors influence South Asian women's attitudes to abortion?

1. Abstract

Women obtain an abortion within different personal, social and economic circumstances that influence the meaning of an abortion and how others respond to women who have an abortion. The purpose of this review was to identify and synthesise research, which has investigated South Asian women's attitudes to abortion. A systematic electronic search of the following databases was undertaken: CINAHL, ASSIA, MedLine, PsycInfo, EMBASE, Web of Science and Knowledge between January 1990 to August 2010. Two hundred and sixty-five papers were identified and of these, ten papers met the inclusion criteria and were included in the review. The methodological quality of all studies was assessed in accordance with established criteria. There were five key themes, which were identified during the process of data synthesis. These include (1) the role of the family, (2) faith and religion, (3) perceived severity of condition, (4) career prospects and education, and, (5) duration of gestation. The review highlights that the experience of an abortion appears to vary as a function of a woman's ethnicity, religious, and moral beliefs and those of others in their immediate social environment. Women's experiences of abortion are also likely to be influenced by their personal appraisals of pregnancy and motherhood. Importantly, although ethnic differences exist there are also variations in attitudes within ethnic groups and acculturation effects need to be considered in relation to this.

Key words: abortion, termination of pregnancy, attitudes, ethnicity

2. Introduction

In 2009 the abortion statistics (Department of Health [DoH, 2009]) recorded the total number of abortions at 189,100 and of those women whose ethnicity was recorded, 76 percent were reported as White, 10 percent as Black British and 9 percent as Asian and Asian British. Furthermore, 34% of women having abortions in 2009 had previously had one or more abortions. Interestingly, the Office for National Statistics (ONS, [1997]) reports that one in three women are likely to have at least one abortion in her reproductive lifetime. These findings suggest that abortion is a common experience amongst women and is no longer restricted to a minority of women. In addition, these statistics indicate that differences between ethnic groups exist.

The National Survey of Sexual Attitudes and Lifestyles-I (NSSAL-I [Johnson, Wadsworth, Welling & Field, 1994]) has attempted to look at this difference and highlights considerable variation in sexual behaviour and ethnicity, in particular initial sexual experiences and first sexual intercourse. The NSSAL-I found that Asian women begin their sexual experience three years later than Black and White women, with a median age of 21. However, despite later sexual activity and an increased tendency for sex to take place within marriage, the survey found that Asian women were more likely to have an abortion at some point in their lives than White women (Johnson et al, 1994). However, the DoH (2009) has reported lower rates for the last year. It is likely that cultural norms change overtime and ethnic variations exist in attitudes, beliefs and behaviour.

2.1 South Asian women

The 2001 census (ONS, 2001) indicated that the United Kingdom (UK) had a population of 56,789,194 people and of these 7.9% indicated that they belonged to a non-white group. More specifically, 4% of the total UK population, which can be simplified to Indian (1.8%), Pakistani (1.3%), Bangladeshi (0.5%) and other (0.4%). Of particular significance is that South Asian (also referred to as simply 'Asian') populations represent the largest minority group in Britain. This is a

heterogeneous group, with varying social norms and religious/ cultural beliefs (Mason, 2000).

The findings of the census suggest that differences exist between ethnic groups therefore it is important to establish what research has been conducted with this population. It is crucial to understand and explore these variations as this has significant implications for health, healthcare services, policies and legislation. This is particularly significant because abortion is a common experience amongst these women and South Asians form a largest minority group. The category 'South Asian' has been adapted because this category has already been established by surveys and epidemiological studies for ethnic monitoring purpose.

2.2 Abortion/ termination of pregnancy

Studies examining factors influencing negative psychological consequences of report that some women are at greater risk than others. Bonevski & Adams (2001) summarised international literature investigating psychological consequences following an abortion between 1970 and 2000. They found that overall in healthy women impulsivity, low-self esteem, limited social support, late-gestation abortion, previous psychiatric illness and conflict with religious or cultural beliefs appeared to predict negative psychological consequences following an abortion. These findings suggest that there can negative outcomes following an abortion. However, the relationship is complex because the reasons for an abortion and the decision to have an abortion can be influenced by many factors, which may vary between or within ethnic groups. Attitudes are also likely to play an important role and are perhaps informed by the social, cultural and religious systems surrounding the individual.

2.3 Attitudes and Acculturation

Hogg and Vaughan (1998) define attitude as ' a relatively enduring organisation of beliefs, feelings and behavioural tendencies towards socially significant

objects, groups, events or symbols'. This definition suggests that there is a positive or negative evaluation of an event.

When women obtain an abortion it is likely that they will hold attitudes towards the event, which will be influenced by, cultural, religious and social factors and this may have an impact on behavioural outcomes. Interestingly, Mason (2000) suggests that explanations of variations in the health status of different ethnic communities are deeply engrained in simplistic cultural explanations, which highlight differences in health to variations in behaviour, which are in turn linked to cultural differences. This suggests more complex relationships operate between attitudes and behaviour that are further complicated by the social factors influencing both. Behaviour may reflect well-established beliefs and attitudes that may in turn be influenced by the systems surrounding the individual. There may also be inconsistencies between attitudes and behaviour, which can redirect the behaviour.

Acculturation effects also need to be considered. This is the process through which individuals of one cultural group (usually the minority group) adopt the beliefs of the dominant group. Changes in language preference, adoption of common attitudes and values, becoming members of social groups and loss of ethnic identification can be evidence of the acculturation effect. Interestingly, Charles and Walker (1998) have explored the roles played by age and gender in women's accounts of their own health and their experience of various health concerns. They argue that there are significant generational differences in the way women talk about their health.

These findings highlight that differences exist between women's attitudes and expectations and those of their parents. There are also likely to be generational shifts in attitudes and beliefs as young people may share the social norms of the community in which they are integrating, while their parents and older members of the group may retain more traditional norms. In addition, rising career aspirations have also been identified among girls of Muslim faith (Basit, 2002) and may be an important factor when considering an abortion.

2.4 Health inequalities

Mason (2000) reports significant health inequalities between people of different ethnic groups, in particular between the white and minority ethnic populations. These are manifested in differences of general health and in the incidence of specific conditions.

One area in particular, where variations by ethnicity have been reported is in the access and usage of preventative services. There is evidence that women from ethnic minority groups use antenatal services less frequently (Petrrou, Kupek, Vause & Maresh, 2003) and a higher proportion book too late for screening to be useful (Ades et al. 2000). Also, women in some ethnic groups have low uptake of potentially life saving cervical cancer smears. The percentage of women aged 16 to 74 reporting having a cervical smear in the previous 5 years being below the UK average of 77 percent in the South Asian groups, especially the Bangladeshi women (33% [Rudat, 1994]). Evidence also suggests that ethnic minority women, especially Pakistani and Bangladeshi women, may have unmet family planning needs (Rudat, 1994). These findings suggest that although different ethnic groups are provided with the same treatment, this may still lead to health inequality particularly if issues related to ethnic diversity are not addressed in healthcare delivery. It is important to explore the degree to which healthcare seeking behaviour is inhibited and what health inequalities may exist in relation to abortion.

Moreover, the measures used to address illness and delivery of services is embedded in the way in which the incidence of any condition is explained (Mason, 2000). They are also related to the level of priority attached to any particular disease or group of individuals. This is problematic as it blames individuals for the condition and places responsibility on the individual themselves for resolving it and therefore low levels of priority is attached to the area (Mason, 2000). Of particular concern is the failure of the National Health Service (NHS) to be responsive to the needs of minority ethnic groups. For example, in the case of illnesses specific to minority groups, such as sickle cell disease and thalassaemia there is a failure to provide sufficient services

(Anionwu, 1993).

Even when services are provided, they may not be equally accessible to ethnic groups. In addition, inequalities arising from cultural differences, such as religious beliefs, stereotypes or limited English translation facilities can lead to problems in minority ethnic communities accessing services that are available. In recent years there has been efforts to improve access problems. However, Mason (2000) suggests that these have been predominately local in nature and frequently rely upon the initiatives of committed individuals or groups. Furthermore, Anionwu (1993) suggests that in many cases it has been the demands of minority ethnic groups themselves that were most significant in stimulating action.

2.5 Further considerations

All the issues raised need to be considered within the wider context of South Asian women and their health. The ways in which women view their own health and their personal understandings of health and illness will affect how specific interventions or procedures such as abortion are considered. Existing research exploring attitudes may highlight the extent to which cultural, religious and social factors account for these ethnic variations. This will have implications for clinical care and service delivery, and will provide insight into how services need to be developed and/ or improved for South Asian women considering an abortion or following an abortion. In addition, services such as planning for linguistic diversity may need to be addressed and culturally sensitive healthcare may need to be provided. Finally, it will give some indication of whether research is including diverse populations in their clinical trials and whether they use appropriate outcome measures. Development of these areas will in turn, impact on the efficacy and effectiveness of interventions. Furthermore, understanding South Asian women's attitudes towards abortion will provide an important contribution to public health and insight into the psychological needs of these women and may be useful in informing and developing psychological services for women in general, with an awareness of the needs of South Asian women. The needs of individuals are diverse and complex and some may require

specialist assessment, counselling and care. Clinicians may need to remain sensitive to issues that have the potential to cause distress to these women.

Given the ethnic variation and health inequalities in areas such as the uptake and usage of services and perhaps cultural/ ethnic variations inhibiting health-seeking behaviour, this systematic review aims to establish whether ethnicity is accompanied by a set of attitudes/ beliefs about abortion, which reflects the way, an individual thinks and the potential impact that this can have on behaviour.

As suggested by Mulrow (1994) this systematic review explores whether existing findings of studies in this specified area of interest are reliable and can be generalised across populations and settings. The review explores differences in attitudes between ethnic groups, and considers the implications that this has for healthcare services and policy makers.

The purpose of this systematic review is to attempt to identify and appraise all available research (both qualitative and quantitative) investigating South Asian women's attitudes towards abortion. Relevant research studies have been selected for inclusion using pre-defined inclusion criteria and studies are excluded on the basis of this. The quality of each study included in the review has been assessed and the findings have been critically explored, evaluated and synthesised. The outcomes of these studies are considered in relation to their strengths and shortcomings.

2.6 Aims

The aim of this systematic review is to identify and explore all published and unpublished research investigating South Asian women's attitudes towards abortion. Women obtain an abortion within different personal, social, and economic circumstances and their attitudes and experiences are likely to be influenced by their ethnicity and culture, spiritual, and moral beliefs and those of others in their immediate social environment.

Review question

What factors influence South Asian women's attitudes to abortion?

3. Methods

3.1 Inclusion and Exclusion Search Criteria

The table below provides details of the criteria that were used to determine whether a research study was suitable for inclusion within this review.

Table 1: Inclusion/ exclusion criteria

Criterion	Rationale
The search was restricted to studies conducted in the last twenty years (January 1990 and August 2010 inclusive)	The aim of this was to elicit a comprehensive review of recent literature and explore the changing nature of attitudes, ethnic identity and practices
Only research for which translation in the English language was available was considered for inclusion within this review	This was reflective of the linguistic abilities of the reviewer and time constraints upon this review. It was also in consideration of the difficulties that can be inherent to translation of research, and the interchangeable use of terminology.
Only research, which had undergone the peer-review process, was assessed for inclusion within this paper	This reflects the purpose of a systematic review, namely to provide a synthesis of previous high quality research within the field of investigation. The peer review process was considered to be an good marker for the quality of research
Only research conducted with South Asian (Bangladeshi, Indian and Pakistani) female adults was included in this review	This was reflective of the population and ethnic group of interest

Table 1 continued: Inclusion/ exclusion criteria

Criterion	Rationale
Both published and unpublished research was considered for inclusion within this review	This was to ensure that all relevant research was reviewed. However, consistent with the previous criterion, only research, which had undergone the peer-review process, was considered
No restrictions were placed upon studies with regard to methodological approach. Therefore, both qualitative and quantitative studies were included in the review	This reflected the methodological diversity seen in the psychological research field, particularly within nursing, social sciences and mental health contexts
Only studies reporting psychological factors and abortion/abortion, which were conducted with the population of interest, were included in the review	This reflected the issues and contexts of interest and therefore were considered most appropriate to include
Studies solely reporting the medical procedure of abortion/ abortion were not considered for inclusion within this review	These studies were considered irrelevant as they were not significant to the review question
Studies exploring attitudes (or similar concepts) to abortion/ termination of pregnancy were included in the review	This reflected the issues of interest

The inclusion and exclusion criteria were applied at every stage during the screening process

3.2 Searching

Prior to conducting the search an initial scoping phase was undertaken to identify relevant Medical Subject Headings (MeSH) terms and keywords. MeSH is used for the purpose of indexing journal articles in social science and is a consistent way of retrieving information that use different terminology for the same concepts. This process included consideration of synonyms, abbreviations, related terms, singular/ plural, medical terminology and British and American spelling. During this phase each database was experimented with in order to devise the most suitable search terms and search strategy to use. Due to each database having its own indexes each database was searched separately. Attention was given to the text words contained in the title and abstract and to the index terms used to describe the articles.

The term 'South Asia*' was initially used as a search term. However, articles, which were elicited from using this term, were considered irrelevant because these were studies conducted in various parts of the world and most articles were not with the population of interest. Therefore, this search term was abandoned and simplified to specifically obtain research studies conducted with Bangladeshi, Indian and Pakistani populations.

A comprehensive search of relevant databases was undertaken to obtain data for the systematic review. In order to identify the most relevant studies for the systematic review all search terms were entered into the following electronic databases: CINAHL, EMBASE, MedLine, PsycInfo, ASSIA, Web of Science and Knowledge. The databases, which were selected and searched, were dependent upon the review topic. These databases were viewed as important sources as they were relevant to the subject area being investigated. That is, databases related to psychology and the psychological aspects of related disciplines, women's health, nursing and healthcare.

Keyword searches

To search the content of databases a simple search strategy consisted of generating key words or concepts derived from the research question. These

search terms were entered into the database and operate by scanning the title and/or abstract for these terms and associated terms. This was important because international literature was searched and different terminology may have been used.

Operators and combination searches

A significant operator, which was used to search the databases, was the truncation or wildcard operator. This is a symbol either the asterisk or dollar sign in some databases which was substituted for a suffix. Phrasing was also a valuable strategy that was used. This involved entering an entire phrase into the database rather than individual terms.

Terms were connected using Boolean operators such as 'AND' and 'OR'. Connecting the words with 'AND' only located items which featured both items and narrowed the search. Connecting the word with 'OR' located items which contained either items and broadened the search.

The first group of searches were conducted using the terms: abortion of pregnanc*, OR abortion* and were mapped to the subject headings in each database. The same process was used to conduct a second set of searches using the terms: belief*, attitude*, view* and perception*. The same process was again used to conduct a third group of searches using the terms India*, Pakistan* and Bangladesh*.

Each item from search one was then combined with each item from search two and then these were combined with each item from search three. This generated the final set of data (research articles) from each database, which were then screened.

Final search terms used in the Medline database

Terms: 'abortion of pregnanc*', abortion*, attitude*, view*, perception*, belief* Pakistan* India*, Bangladesh*,

These search terms were modified slightly when searching the other databases (see appendix one).

The table below shows the number of articles retrieved from the databases.

Database	Number of articles retrieved
EMBASE	68
Web of Science and Knowledge	37
PsycInfo	97
MedLine	42
CINAHL	18
ASSIA	3
Total number of articles	265

Table 2: Total number of articles retrieved from each database

Searching other resources

Once articles were identified, the details of the articles were entered into Google Scholar. The aim of this was to access further papers, which have cited the article of interest. Citation searching using Google Scholar involved selecting a number of key articles already identified for inclusion in the review and then searching for articles that have cited these articles, in order to identify further articles. There was one article, which was included from this process of cross-referencing in the final synthesis. The final articles, which were included in for review, all met the inclusion criteria.

3.3 Data selection

Screening stage one

This stage involved an initial screening of titles and abstracts against the inclusion criteria to identify potentially relevant articles. There were many articles, which were considered irrelevant (most related to the medical procedure and not exploring issues of interest) and were excluded during this process (see table 3).

Database	Number of excluded	Number of remaining articles
EMBASE	54	14
Web of Science and knowledge	27	10
PsycInfo	88	9
MedLine	32	10
CINAHL	4	14
ASSIA	2	1
Citation searching	0	1
Total number of articles	207	59

Table 3: Number of articles excluded and remaining articles

Screening stage two

At this stage all the articles generated from the databases were collated together and duplicated articles both across databases and within databases were removed. In total 40 duplicated articles were identified and removed. There were 19 remaining articles at this stage.

Screening stage three

This stage involved screening of full articles identified as potentially relevant to the review. During this process three articles were removed because these studies did not meet the inclusion criteria. Specifically, these were studies that were conducted in the 1970s.

The remaining 16 articles were read in full and assessed in relation to the inclusion criteria. They were also considered according to their relevance to the review. One article was excluded because although this study stated that they included women from an ethnic minority it was not specified exactly which ethnic group these women belonged to. Therefore, it was not beneficial to include this study due to the purpose of the review. Another study was excluded because it included only white and black women and therefore, did not meet the inclusion criteria. Two further studies were excluded. Although these studies were deemed to be relevant at the initial screening stage following analysis of the articles they were considered irrelevant to the issues being explored. These studies specifically investigated women's experiences

of undertaking an abortion. Finally, a further two research paper was removed because although it investigated perceptions of a diverse group of women it did not differentiate the South Asian women in the paper.

Following application of the inclusion/ exclusion criteria, ten articles remained for review these are presented in table 4 below. More recent publications are presented first with authors in alphabetical order. There were four qualitative and six quantitative articles generated from the final search.

Study number	Authors	Year	Title
1	Gupta	2010	Exploring Indian women's reproductive decision-making regarding prenatal testing
2	Ahmed et al.	2008	Decisions about testing and abortion for different fetal conditions: a qualitative study of European white and Pakistani mothers of affected children
3	Arif et al.	2008	Attitudes and perceptions about prenatal diagnosis and induced abortion among adults of Pakistani population
4	Eskild et al.	2007	Childbearing or induced abortion: the impact of education and ethnic background. Population study of Norwegian and Pakistani women in Oslo, Norway
5	Hewison et al.	2007	Attitudes to prenatal testing and abortion for fetal abnormality: a comparison of white and Pakistani women in the UK
6	Ahmed, Atkin, Hewison & Green	2006	The influence of faith and religion and the role of religious and community leaders in prenatal decisions for sickle cell disorders and thalassaemia major
7	Ahmed, Green & Hewison	2006	Attitudes towards prenatal diagnosis and abortion for Thalassaemia in pregnant Pakistani women in the North of England
8	Shah, Baji & Kalgutkar	2004	Attitudes about medical abortion among Indian women
9	Barrett, Peacock & Victor	1998	Are women who have abortions different from those who do not? A secondary analysis of the 1990 national survey of sexual attitudes and lifestyles
10	Houghton	1994	Women who have abortions- are they different?

Table 4: Studies included in the review

Literature search strategy

Databases: EMBASE, PsycInfo, CINAHL, MedLine, ASSIA, Web of Science and Knowledge

Limits: English articles only
Adults (above 18 years)
Research conducted in between January 1990 and August 2010
(past two decades)

Identification

Number of records
identified through
database searching
= 265

Number of additional
records identified
through other sources
= 1

Screening

Number of records
screened = 265

Number of records
excluded = 207

Number of records
after duplicates
removed = 40

Number of records
excluded = 19

Eligibility

Number of full-text
articles assessed for
eligibility = 19

Number of full-text
articles excluded, due to
unsuitability = 9

Included

Number of studies included in
qualitative synthesis = 10

Figure 1: flow of information through the different phases of a systematic review (adapted from the Preferred Reporting Items for Systematic reviews and Meta-Analyses [PRISMA], 2009)

3.4 Assessment of methodological quality

The primary reviewer screened the titles and then selected research articles for inclusion in the review. Research papers selected for retrieval were assessed in accordance with the inclusion/exclusion criteria. Qualitative and quantitative studies were considered in this review.

There are several rating scales (e.g. Strengthening Reporting of Observational Studies in Epidemiology scale (STROBE; von Elm, et al. 2007), the Newcastle-Ottawa Scale (NOS, [Wells et al., 2009]) and the NHS based Critical Appraisal Skills Programme (CASP, 2006) which have been developed to assess the quality of studies. The NOS was selected to use as a guide for assessing quantitative research due to the scales simplicity and easy usage. The NOS has been previously used in systematic reviews (Molnar, Patel, Marshall, Man-Son-Hing, & Wilson, 2006) and is a 9-point scale that rates studies in terms of their selection of participants, comparability, assessment of exposure and outcome. The NOS was supplemented with a componential approach (see Sanderson, Tatt & Higgins, 2007). This addresses methods for selection and measurement of variables, bias related to the design of the study, methods used to control for confounding variables and the appropriateness of the statistical method used. The NOS was considered unsuitable for qualitative studies due to being underpinned primarily by a positivist approach and was not sufficiently adaptable to other methodologies. Therefore, to assess the methodological quality of qualitative studies the CASP (2006) tool was used. This tool relates to the principles or assumptions that characterise qualitative research.

Data extraction

For each study the following information was recorded: author, date of publication, demographics of the study population, methods/measures used, outcome and the studies main findings. The NOS scale and CASP tool was applied to in the assessment of methodological quality of identified studies to ensure evidence is accurately reported and summarised.

The data extracted from the studies was obtained independently.

Data synthesis

A qualitative approach to the systematic review was adopted because it has been recommended that a meta-analytic procedure is unsuitable for sample studies less than 50 (Papworth and Milne, 2001). In this case this approach involved using appraisal criteria and applying it to the articles included in the review. This criterion relates to the methodological quality of the studies, the relevance and credibility that can be attached to the results. This is an objective and transparent approach to assess data and synthesise research with the aim of minimising bias.

There was a large heterogeneity in terms of population, outcome measures and methodology and therefore conducting a meta-analysis was considered inappropriate. Furthermore, there are many shortcomings of undertaking meta-analytic procedures for example, Slavin (1995) proposes that poor quality studies are often included in a meta-analysis as they are masked through statistical presentation of results and this influences the mean effect size.

4. Results

The findings and methodological quality are summarised in the tables below. Table 5 provides the characteristics and main findings of the ten studies included in the review. Table 6 assesses the methodological quality of the six quantitative studies using the NOS and uses a componential approach. The methodological quality of the four qualitative studies is then assessed using CASP tool.

Table 5: Characteristics and main findings of identified studies

Author and Year	Sample Size	Population studied and location	Methodology	Measures used	Main findings
Gupta (2010)	47 women	Pregnant women (early twenties to late thirties) Large private trust hospital in New Delhi, India	Qualitative	Semi-structured interview with pregnant women and observation of client- provider interaction during genetic counselling sessions	<ul style="list-style-type: none"> - The choices these women make are influenced by family, kinship and their community - The cost of tests and clients capacity to pay is an important factor in women's use of prenatal testing - Pregnant women who decide to undergo prenatal testing and then choose to have an abortion due to an affected foetus make 'pragmatic decisions' and view it as a duty to themselves, their family and the unborn child's future - Genetic counsellors are heavily relied upon for advice
Ahmed et al (2008)	19 women	Nine European women and 10 women of Pakistani origin NHS genetics department, West Yorkshire, United Kingdom	Qualitative	Self-completion questionnaire followed by a semi-structured interview	<ul style="list-style-type: none"> - The most important factor in the majority of women's decisions about having an abortion was their perception of 'they believed the child would suffer both physically and emotionally - The main difference between the groups was the role of religion in decision-making. Most Pakistani respondents mentioned that their religion does not allow an abortion compared with one European respondent

Author and Year	Sample Size	Population Studied and location	Methodology	Measures used	Main findings
Arif et al (2008)	345 respondents	171 male (49.6%) 174 female (50.4%) Out-patient clinics of Community Health Centre and Consulting Clinics of the Aga Khan University Hospital, Karachi Pakistan	Quantitative	Questionnaire	<ul style="list-style-type: none"> - 23% of the sample were accepting of an induced abortion if the foetus had serious congenital anomalies - 15% would not consider an abortion under any circumstances - Women held more favourable attitudes towards induced abortion - Mutual consultation of husband and wife for making a decision to have an abortion was important for 84% of the sample
Eskild et al (2007)	99,818 women	94,428 Norwegian women and 5,390 Pakistani women Oslo, Norway	Quantitative	Population based study where data was accessed from the Norwegian central person registry	<ul style="list-style-type: none"> - For women living in Oslo childbirth was more common in Pakistani than in Norwegian women - In Norwegian women, low education was associated with lower frequency of child delivery but higher frequency of induced abortion - In Pakistani women, child delivery was not related to education, but induced abortion was more frequent with those with a university education

Author and Year	Sample Size	Population Studied	Methodology	Measures used	Main findings
Hewison et al (2007)	420 women	222 white women 198 women of Pakistani background Antenatal clinics, UK	Quantitative	Questionnaire	- Pakistani women held significantly more favourable attitudes towards prenatal testing but less favourable attitudes towards abortion when compared with White women - Most women from both ethnic groups wanted some prenatal testing and of the 30 conditions investigated most would consider an abortion for some conditions
Ahmed, Atkin, Hewison & Green (2006)	In phase 1= 49 male and female participants In phase 2= 8 women participants and 3 males	Pakistani Muslim men = 5, women = 4 Indian Hindu men = 6, women = 9 Indian Sikh men = 9 women = 6 African-Caribbean men = 5, women = 5 Phase 1: Community organisations in the North of England Phase 2: voluntary organisations in Sheffield and Birmingham	Qualitative	Phase 1- eight focus groups (consisting of each faith community) Phase 2- two focus groups with mothers of children with Sickle cell disorders and Thalassaemia major. Also two fathers interviewed- two with a child with Thalassaemia major and one with a child with Sickle cell disorder	- Muslim populations were more likely to decline prenatal diagnosis and abortion because of their religious beliefs however, the decision-making process in individually based and occurs within the context of broader social relationships, in which faith and religion is only one aspect - The perceived severity of a condition plays an important role in the decision-making process whereas religious and community leaders play a very little role in this process

Author and Year	Sample Size	Population Studied	Methodology	Measures used	Main findings
Ahmed, Green & Hewison (2006)	43 women	Pregnant Pakistani Muslim women Midwifery and Genetic services in two cities in the North of England	Qualitative	Semi-structured interviews	<ul style="list-style-type: none"> - Complex relationship between attitudes towards prenatal diagnosis and attitudes towards abortion, in which attitudes towards prenatal diagnosis are not a good proxy for attitudes towards abortion - Religion was an important factor in the decision-making about having an abortion but other factors also play a role (e.g. severity of the condition, views of the family)
Shah, Baji & Kalgutkar (2004)	250 women	Indian pregnant women Nowrosjee Wadia maternity hospital, Mumbai, India	Quantitative	Questionnaire to explore women's attitude towards abortion, prior to and after the procedure	<ul style="list-style-type: none"> - A questionnaire administered post-abortion highlighted that most women viewed medical abortion as an excellent method and the procedure was better than their expectation - Women prefer hospital management of medical abortions as they are assured of prompt medical treatment for side effects or complications and are satisfied with non-invasive methods

Author and Year	Sample Size	Population Studied	Methodology	Measures used	Main findings
Barrett, Peacock & Victor (1998)	5576 women	103 described as 'Asian' London, UK	Quantitative	Questionnaire	<ul style="list-style-type: none"> - The likelihood of ever having had an abortion increased significantly with age - Ethnicity and religion were also important factors in Black and Asian women - The profile for Asian women included generally being older mainly non-Christian (mostly Hindu, Sikh and Muslim), married, had lower number of lifetime partners and were more likely to have children
Houghton (1994)	131 women	131 attenders at a day-centre were compared with two other groups: a random sample of 142 women from the local Family Health Services Authority age-sex register and 149 consecutive attenders at the district's antenatal clinic in London UK	Quantitative	Questionnaire	<ul style="list-style-type: none"> - Ethnic origin was related to tenure and educational achievement with UK origin white women having higher social class indicators and contraceptive knowledge - Past abortions or past risk of unwanted pregnancy was not related to ethnic origin - The authors suggest the findings are a reflection of cultural attitudes to fertility, sex and contraception

Table 6: Assessment of methodological quality of quantitative studies

Author & year	Adequate selection methods	Design biases present	Adequate conceptualisation and assessment	Statistical analyses	NOS score
Arif et al (2008)	Yes. Population is well described in relation to age, gender, marital status, ethnicity, level of education and monthly income.	<ul style="list-style-type: none"> - Study conducted in private tertiary care hospital primarily with individuals from a relatively higher social class - Questionnaire administered by fourth year undergraduate students - The questionnaire done in English, translated into Urdu and then back into English - Participants given hypothetical situations 	<p>No. Questionnaire should have been administered in a community setting and therefore not representative of population</p> <ul style="list-style-type: none"> - No control group <p>Adequate assessment tool</p>	<ul style="list-style-type: none"> - Sample size less than calculated using Epi-Info-6 - Cross-sectional study with descriptive statistics of the sampled population - Both uni- and multivariate analyses used 	<p>Selection = 1 Comparability = 1 Outcome = 2</p> <p>Total score = 4</p>
Eskild et al (2007)	No. Archival data obtained from the Norwegian Central Persons Registry	<ul style="list-style-type: none"> - Population statistics likely to be outdated. Not stated why women with residency in Oslo during 2000 and 2002 were included in the study - Information on education missing for large proportion of Pakistani women authors conclude this is reflective of poor education 	Adequate assessment tool for measuring the impact of ethnicity on child-birth and induced abortion however unclear how accurate and up-to-date data is	<ul style="list-style-type: none"> - Population based survey - Multiple logistic regression analysis 	<p>Selection = 1 Comparability = 1 Outcome = 1</p> <p>Total score = 3</p>

Table 6 continued: assessment of methodological quality of quantitative studies

Author & year	Adequate selection methods	Design biases present	Adequate conceptualisation and assessment	Statistical analyses	NOS score
Hewison et al (2007)	Yes. Geographical area stated, demographical characteristics of study participants given	<ul style="list-style-type: none"> - Participants in the study had recently had a healthy baby, this may have impacted on their responses - The study used hypothetical situations therefore same choices may not be made in real-life situations - The wording of the conditions may have influenced responses - Some questionnaires were administered by post whereas others were interviewer assisted 	<ul style="list-style-type: none"> - Clear comparison groups - Questionnaire developed by multi-disciplinary group of professions 	A hierarchical cluster analysis identified a principle dimension, reflecting the seriousness of the condition and a cluster of severely disabling conditions	Selection = 2 Comparability = 2 Outcome = 2 Total score = 6
Shah, Baji & Kalgutkar (2004)	No. Insufficient details given to ascertain the sample	<ul style="list-style-type: none"> - Study conducted at least 6 years prior to being reported - 205 of 250 women belonged to lower socioeconomic groups and the vast majority were house wives 	<ul style="list-style-type: none"> - No details given about the assessment tool - Methodological approach does not allow for the exploration of attitudes 	No statistical analysis performed simply percentages for women's reasons for accepting medical abortion and views on medical procedure	Selection = 1 Comparability = 0 Outcome = 1 Total = 2

Table 6 continued: assessment of methodological quality of quantitative studies

Author & year	Adequate selection methods	Design biases present	Adequate conceptualisation and assessment	Statistical analyses	NOS score
Barrett, Peacock & Victor (1998)	- Yes. This was a secondary analysis of data which is somewhat representative of the UK population	- Categorisation of ethnicity ambiguous - Small number of Asian women included - Asian women are simply categorised according to their religious beliefs	- Due to the original data being in relation to HIV and AIDS its main aim was not a study of abortion so there is lack of detail around circumstances surrounding the abortion - The study does provide some knowledge in an area which at the time was under researched	Unifactorial analyses of relations with abortion performed, followed by multifactorial analysis (logistic regression) to determine which characteristics are independently associated with abortion	Selection = 1 Comparability = 1 Outcome = 2 Total = 4
Houghton (1994)	Yes, geographical area stated and population well described	Definitions and selections of controls can be problematic - Women with various ethnic origins are grouped together and compared to white women - Majority of women included were in the first trimester of pregnancy	- No. Ethnicity not defined or explored in any great detail - Insufficient detail about the assessment tool	Comparative study with two control groups Analysis involved descriptive analysis of each group, comparative analysis between the three groups and adjustments for age and ethnicity	Selection = 1 Comparability = 1 Outcome = 1 Total = 3

The following section assesses the methodological qualities of qualitative studies.

The CASP tool has two screening questions. The first relates to whether there are clear aims to the research and the second whether the qualitative methodology was appropriate. For all qualitative studies included in the review there were clear aims for the research and an appropriate methodology was used. The following section assesses the methodological quality of these studies in a systematic way by applying the CASP criteria.

Appropriate research design	- Adequate, but no justification is given for why the design was selected
Sampling	<ul style="list-style-type: none"> - Participants were selected from a large private trust hospital. This poses problems as most women were from an affluent background. - Participants were recruited because they were pregnant and had been referred to the genetic and ultrasound departments. The authors wanted to ask participants about their knowledge and source of information in this area therefore the recruitment strategy was appropriate to the aims of the research
Data collection	<ul style="list-style-type: none"> - 47 semi-structured interviews and observation of client-provider interaction during genetic counselling sessions - Observation can be a subjective process - During some interviews family members were present and this has the potential to bias the results - Some indication of topic guide - Form of data unstated (although quotes used) - Researcher does not discuss saturation of data
Reflexivity	Not considered
Ethical issues	<ul style="list-style-type: none"> - Ethical approval was obtained from the ethical committee of the hospital - Participants were explained the rational of the study and consent obtained (unsure whether this was written or verbal)
Data analysis	<ul style="list-style-type: none"> - Limited discussion of the analysis process - The researcher does not acknowledge any limitations of the study and potential bias is not considered
Findings	<ul style="list-style-type: none"> - Author suggests new areas for research - Findings are explicit and discussed in relation to original research question - Credibility of the findings is not discussed
Value of the research	<ul style="list-style-type: none"> - Contributes to the theoretical discussions on the construction of choice and autonomy regarding reproductive decisions in relation to prenatal testing - Suggestions are made for service development

Appropriate research design	Yes. The design is justified and appropriate as this study explores participants views in relation to testing and termination of pregnancy
Sampling	<ul style="list-style-type: none"> - Participants were recruited from an NHS genetics department - The sample was appropriate and is well described - Participants selected are appropriate for the aims of the research - There is some discussion around recruitment
Data collection	<ul style="list-style-type: none"> - The setting was appropriate for data collection and details are provided about how the data was collected with justification for this - The interview topic guide is attached as an appendix - Tape-recordings were used and data saturation is discussed
Reflexivity	Not considered
Ethical issues	<p>There is sufficient detail to assess whether ethical standards were maintained</p> <ul style="list-style-type: none"> - The appropriate local ethics committee approved the study - Written consent was obtained from participants - Other issues e.g. women's preferred language was addressed
Data analysis	<ul style="list-style-type: none"> - Framework analysis was used to analyse the data and justification is provided for why this analysis was selected - There is some description of how the categories and themes were derived from the data - Data to support and contradict argument is considered <p>The researchers do to some extent look at how they might have biased the results of the study:</p> <ul style="list-style-type: none"> - Hypothetical situations used and therefore behaviour may be different in real life - Potential for social desirability effects - Structure may have limited women's responses <p>Risk of possible bias arising from only asking Pakistani participants about their religious beliefs not considered but problematic as the main difference between the two groups was the role of religion in decision-making</p>
Findings	<ul style="list-style-type: none"> - Findings are explicit and there is adequate discussion for and against the researchers arguments - Credibility of findings not discussed - The findings are discussed in relation to the original research question
Value of the research	<ul style="list-style-type: none"> - The findings have practical implications for clinical practice and highlight the importance of recognising diversity within ethnic groups - New areas for research are identified

Appropriate research design	<p>Yes. The study uses a combination of interviews and focus groups. This was required to explore the role of faith and religion, perceived severity of the conditions and religious and community leaders in making decisions about prenatal genetic screening, prenatal diagnosis and termination of pregnancy.</p> <ul style="list-style-type: none"> - There is justification by the researchers for using this methodology
Sampling	<ul style="list-style-type: none"> - The sample encompasses four different faith communities with eight different focus groups (phase 1) Individuals in the four faith groups were divided into male and female. Phase 2 involved recruiting parents from voluntary organisations - Demographics of the study and participant characteristics are provided and recruitment process is discussed
Data collection	<ul style="list-style-type: none"> - There is justification for collecting data from community and voluntary organisations - It is clear how the data was collected and the structure is specified e.g. used a facilitators guide for focus groups and interviews
Reflexivity	<ul style="list-style-type: none"> - The relationship between the researcher and participant was only considered when deciding which gender should conduct the focus groups and interviews - No further considerations
Ethical issues	<ul style="list-style-type: none"> - Written consent was obtained but it is unclear if ethical approval was obtained from an ethics committee
Data analysis	<ul style="list-style-type: none"> - There is some discussion of the process of data analysis and the framework used - Researchers explain how transcripts were organised, coded and analysed - There is also reference to how key themes/categories were identified but saturation of data is not discussed - There is adequate data to support the findings however, contradictory data is not taken into account - The researchers acknowledge that the study may be biased because people with more conservative views may have been unlikely to take part and that recruitment of individuals from particular organisations could have influenced the results of the study as these members may have more similar views
Findings	<ul style="list-style-type: none"> - The findings are explicit and structured according to themes and discussed in relation to original research question - The credibility of the findings are not discussed
Value of the research	<p>Recognise diversity within different faith groups and moves away from generalisations based on people's ethnicity or religion, this has implications for current practice and service planning, also new areas for research are not identified</p>

Appropriate research design	Yes, study has clear objectives and the design is appropriate to this
Sampling	<ul style="list-style-type: none"> - Demographics of the study and participant characteristics are provided and the recruitment process is discussed - Services where participants were accessed through are discussed
Data collection	<ul style="list-style-type: none"> - The setting for data collection is justified - It is clear how the data was collected but details are not provided of how the interview guide was produced from the review of literature - Sufficient detail is given about the questions explored during the interviews - Interviews were conducted in several South Asian languages, this questions reliability of the analysis of the data due to the translation of words into English, the researchers acknowledge risks of misrepresenting data and losing data - All women in the study were pregnant and this may have impacted on their responses towards prenatal diagnosis and termination of pregnancy - The form of data is clear and the researchers have discussed saturation of data
Reflexivity	Not considered
Ethical issues	<p>There is sufficient detail to assess whether ethical standards were maintained</p> <ul style="list-style-type: none"> - The appropriate local ethics committee approved the study - Written consent was obtained from participants
Data analysis	<ul style="list-style-type: none"> - Method of analysis described in reasonable depth - It is clear how themes were derived from the data and there is adequate information of how the data was selected - Sufficient data is presented to support the findings and contradictory data is not considered - The researcher does not acknowledge any limitations of the study and potential bias is not considered
Findings	<ul style="list-style-type: none"> - The findings are explicit and are discussed in relation to the original research question through themes <p>The researchers do not discuss the credibility of their findings</p>
Value of the research	<ul style="list-style-type: none"> - Implications for service provision, including training of health professionals and new areas for research suggested - Findings can be applied to other Muslim populations

4.1 Data synthesis

All ten studies included in the review were considered together when synthesising the results of the study. To begin with the key findings of each study was extrapolated and summarised. This process was facilitated through noting the key concepts used and generating workable lists. From this list the key concepts across studies were identified through systematically searching for the presence or absence of these concepts. The synthesis began with considering the most recent study and continued, until all ten studies had been reviewed. Throughout this process close attention was paid to the similarities and differences between the concepts/themes identified and how these may relate to one another.

The key themes, which were identified during this process, centre around five main topics: the role of the family, faith and religion, perceived severity of the condition, career prospects and education and duration of gestation. A cross-comparison of each study that reported the various themes was conducted.

4.2 *The role of the family*

The family plays a significant role in decision-making in India and Pakistan. Gupta (2010) reports that women in India often face coercion by their husbands and mother-in law in making reproductive decisions. The author reports that a woman's status in the family can determine the extent to which she makes autonomous reproductive decisions. Also women in India are likely to possess limited information, which limits the choices they have available, and the degree of pressure experienced from family members. A study conducted in Pakistan (Arif et al. 2008) found that participants want the decision to have an abortion to be a joint one between husband and wife. The findings from these studies suggest that both parents should be involved in the decision-making process and highlight that appropriate information needs to be provided to both parents during pregnancy so that they feel empowered to make their own reproductive decisions. Gupta (2010) suggests that often women feel that obtaining an abortion is their only choice therefore the government needs to invest more into the public sector to increase facilities

for genetic testing and provide care and support services for the disabled and their families this supports Arif et al's (2008) perspective for Pakistan.

Family also plays a significant role in the decision-making process for South Asian communities living in the UK. Ahmed et al. (2006) has found that family attitudes are important to individuals considering an abortion. Similarly, Ahmed Green and Hewison (2006) suggest that in some cases families make decisions on behalf of Pakistani women (same pattern as found in South Asian countries). Women in the study reported that they would seek the support and views of family members but their belief was they would be discouraged to have an abortion but many found they were supported whatever decision they made. These findings suggest a different pattern in the UK where families can play a supportive role than in India where family members may coerce women into making a decision.

4.3 Faith and religion

Abortion is generally considered to be culturally and religiously unacceptable in Pakistan. However, Arif et al (2008) found in their study in Pakistan that although some people have strong reservations about obtaining an abortion due to their religious beliefs some would be willing to consider an abortion if they were fully informed about the consequences of having a disabled child.

Similarly in the UK, Ahmed, Green and Hewison (2006) found in some instances women would not obtain an abortion in any circumstances whereas in other situations some women felt abortion may be justified. Interestingly, Ahmed et al. (2008) found that most Pakistani women spontaneously mentioned religion unlike the European white women in their study. Importantly, all the Pakistani women said that Islam did not allow an abortion but believed that an abortion was justifiable for severe conditions.

A similar study found although faith and religion were important factors in the decision-making process (Ahmed et al. 2006), the participants reported that reproductive decisions would be based on their personal moral judgements

and beliefs. The Pakistani Muslim group believed abortion was prohibited in Islam and it was important for them to be provided with information to know their religion's stance to abortion. However, this group agreed that religion was not prescriptive and they would make their own decision based on their personal beliefs and values. Some people in this group stated they would still not consider an abortion because of their moral beliefs. These findings are consistent with what other studies have found in the UK and also what has been reported in Pakistan.

Ahmed et al (2006) also explored the role of religious leaders. All Pakistan Muslim participants agreed that they would not consult a religious leader for advice on abortion. This was because they believed that religious leaders were unlikely to appreciate the severity of conditions and would not understand the impact on the affected child and family and therefore, would be more likely to provide biased opinions than advice based on medical knowledge. Furthermore, they believed religious leaders would advise against an abortion and inform them that their religion prohibited abortion. Interestingly, there was no role for religious leaders in the reproductive decision making process. The role of religious leaders has not been explored in South Asian countries. Interestingly, studies report (e.g. Ahmed et al. 2006; Ahmed, Green & Hewison, 2008) that Pakistani Muslim participants had misconceptions in their interpretation of their religion particularly Islam not permitting an abortion. These findings suggest that people have difficulty distinguishing their religious and cultural/traditional beliefs (Ahmed et al, 2000).

Participants' accounts from these studies suggest that although people from South Asian ethnic groups may consider religion when making a decision to have an abortion, this is not always considered to be the most important factor and decisions can occur within a broader context. Participants take into account factors such as values, beliefs and judgements and perceived quality of life for the child and family. Interestingly, it has been suggested that services may be offered late or withheld by health professionals because of assumptions that Pakistani Muslims would not obtain an abortion because of

their religious beliefs (Anionwu & Akin, 2001). The findings of these studies suggest that health professionals should not explain people's behaviour through simple cultural generalisations and it is important to recognise diversity exists both between and within ethnic groups.

4.4 Perceived severity of the condition

The severity and type of disorder has been found to be an important factor in studies exploring prenatal decisions about abortion (Ahmed et al. 2006; Ahmed, Green & Hewison, 2006). Ahmed et al (2006) found that when Pakistani women were deciding whether to opt for an abortion, women made judgements about the quality of life for a child. This included their perception of pain, which would result in emotional and physical suffering for the child. Perceptions of disfigurement were noted and in particular, others adverse reactions (e.g. bullying, staring) to the child. Overall, perceptions of disfigurement played a role in women's decisions about abortion mainly because of the implications for the affected child. Furthermore, if women believed that a child would die in childhood then they would opt for an abortion because of the suffering for the child and distress for parents caused by the death of the child. Situations where women would not consider an abortion included conditions where the child would be able to have some quality of life and also for late onset conditions.

Similarly, Arif et al (2008) and Ahmed et al (2006) indicate the importance of severity of the condition in the decision-making process of obtaining an abortion. An abortion would be considered in conditions where the child would experience pain and suffering. Another study also reports these findings (Hewison et al. 2007). Interestingly, Arif et al (2008) reports that it is social taboo to have a 'mentally disabled child' (pg 1149), and this increases problems for the family. Participants who perceived the conditions in the study to be serious had a higher acceptability of abortion.

Another study also supports these findings. In Ahmed et al (2006) study participants believed that Thalassaemia major resulted in a lifetime of

suffering for the affected child and therefore, wanted an abortion. The prevention of a child's suffering was perceived as more important in influencing decisions than religious beliefs. Some conditions such as sickle cell disorders were not considered serious enough to warrant an abortion and adverse impact on the affected child and family were considered important. Ahmed et al (2006) notes that when considering an abortion Pakistani Muslim participants stated that health professionals would be consulted to obtain factual information because they have the ability to provide factual information about the conditions, their severity and impact on the affected child and family.

All these studies provide consistent evidence for the perception of quality of life according to the perceived severity of a condition, as the most important reason cited for an abortion in the UK amongst the Pakistani Muslim population. They also highlight the perceived significance of health professionals and the need to receive accurate information.

4.5 Career prospects and education

A Norwegian study (Eskild et al. 2007) found women of Pakistani origin were twice as likely to have a child compared with Norwegian women. The level of education was not associated with number of childbirths in Pakistani women. However, interestingly, Pakistani women who were older were more likely to have a termination and it tended to be more common among women with college/ university education. In addition, it has been reported that the level of education has an important influence on health-related attitudes (Hewison et al. 2007). Furthermore, Arif et al (2008) has found in Pakistan that the acceptability of prenatal screening and abortion increases with level of education and also monthly income.

Eskild et al. (2007) suggests that in Pakistani older women, abortion may be a method to reduce the number of children whereas amongst Norwegian women abortion can be a method to delay childbirth and perhaps concentrate on education and future career prospects. These findings suggest that cultural

factors associated with ethnicity may be more important when making reproductive decisions but also the level of education may also be important. This is an area that requires further exploration.

4.6 Duration of gestation

Studies report that participant acceptability of an abortion reduced as the duration of gestation increased. Arif et al (2008) found participants had a greater acceptability of abortion if it was prior to 12 weeks of gestation. Similarly, Ahmed et al. (2006) found participants had a preference for abortion within the first trimester and stated that this preference was related to religious beliefs. In addition, Ahmed, Green and Hewison (2006) found that Pakistani women were more accepting of an abortion if it was earlier on in the pregnancy. The authors suggest that attitudes may also depend on the timing of the abortion for the woman. In addition, abortion was not an option for women who had been trying to get pregnant for a period of time.

These findings indicate that early diagnosis is required and more widespread use of prenatal screening techniques. Arif et al. (2008) reports non-evasive methods have been found to have a higher level of acceptability.

5. Discussion

The findings of the studies suggest that whether a woman decides to bear a child is dependent on social patterns that occur. In addition, women of different ethnic backgrounds have culturally related attitudes and behaviour based on their concepts of health and illness and the role of significant others also influence this.

With studies conducted outside of the UK it is difficult to generalise their findings to South Asian women living in the UK. Differences are likely to exist between these populations including regional differences (Shaw, 2000), educational backgrounds and service provision. Furthermore, studies are likely to be within a patriarchal society where traditionally men make important

decisions within the family. In addition, reproductive patterns and level of education are likely to differ between women in Western and non-Western countries. Efforts to conduct research in the UK in this area have provided some insight into factors, which influence women's decision-making process and highlight some similarity with studies conducted in South Asian countries. However, there are very few studies and although they highlight that ethnic diversity exists within groups further exploration is required. Also, all studies have been conducted with Pakistani Muslim communities in the UK and therefore other South Asian populations have been largely neglected.

In relation to psychology cognitive consistency theories emphasise that people try to maintain an internal consistency, order and agreement between their various beliefs. Of particular significance here is the cognitive dissonance theory (Festinger, 1957), which emphasises that cognitive dissonance is an unpleasant state of psychological tension, which occurs when a person has several cognitions (views, attitudes, perceptions, beliefs) that are inconsistent, and therefore we seek harmony in our attitudes and behaviours and try to reduce tension from inconsistencies. For dissonance to arise and consequently for attitudes to change, it is necessary that circumstances place one set of attitudes in contradiction with another set of attitudes. In relation to abortion and considering acculturation effects it could be that ethnic groups try to reduce dissonance by changing their inconsistent cognitions and therefore the minority group adopts the beliefs and behaviours of the dominant group. In some individuals this dissonance will be greater and therefore there may be stronger attempts to reduce it. However, in some situations dissonance may occur and this can cause distress for individuals. The theory highlights that discrepancies between attitudes and behaviour provide crucial processes through which attitude change can occur. This can have implications for the way interventions and procedures are thought about and also the access and use of services.

The review has relevance in many areas. The findings suggest that health professionals need to be better informed about the potential severity of conditions to be able to provide factual information. They may also need to be

provided with training to recognise the diverse views so they are more confident and willing to talk to people from ethnic groups about reproductive issues. Studies have also indicated that there is some misconception about Islam's stance on abortion. This suggests it may be important for policy makers/ service providers to consult NHS faith chaplains to provide education about the religions view on abortion. Religion is often taken as a proxy for Muslim people attitudes and therefore these individuals may not be offered prenatal screening and/or the option to have an abortion. The review indicates that clinical care when considering or following an abortion needs to be improved for ethnic groups. In addition, important services such as planning for linguistic diversity needs to be addressed and culturally sensitive healthcare need to be provided. In addition, research needs to include diverse populations in their clinical trials and use appropriate outcome measures. This will in turn impact on the efficacy and effectiveness of interventions. Health Authorities need to ensure that they set priorities and monitor service targets whilst remaining sensitive to the community needs. Effective intervention can only be achieved through collaboration with communities, using culturally appropriate mechanisms. Greater sensitivity may need to be paid to the needs of an ethnically diverse population where those organising and delivering care are more representative of the populations they are required to serve.

Due to the impact of sociological factors (such as changing attitudes of women and their families) research in this area has the potential to become quickly dated. There is evidence to suggest that attitudes towards abortion have become significantly more liberal during the 1990s amongst women in the UK (Scott, 1998) but we know little about the ethnicity of these women. Attitudes have the potential to influence stigmatisation and secrecy, which influence disclosure and access to social support that is known to be protective factor against psychological distress in other areas. The United Kingdom is a multicultural society and while significant strides have been made in terms of acceptance of its diversity, there are still unmet challenges. It is imperative to be aware of the role of culture and moral, social and religious beliefs of different ethnic groups as health and social care agencies

face the challenge of providing a service that is equitable to all regardless of ethnic background, particularly, in light of the Race Relations Amendment Act (2000) which enforces a duty on public authorities to be proactive towards meeting the needs of ethnic groups.

Furthermore, following the implementation of the Race Relations Amendment Act (2000) there is a legal duty on the NHS to identify and address issues associated with delivery of healthcare to a diverse population. The Act emphasises that even if different ethnic groups are provided with the same treatment this may still result in inequality and discrimination. In 2004, the NHS Chief Executive published a Race Equality Action Plan that re-emphasised the need for the NHS to examine healthcare delivery to ethnic minority populations, and to address any issues associated with ethnic diversity. With the UK population being so diverse this is an increasingly important area.

Limitations

There are several limitations to this review. To begin with the search strategy was limited to published peer-reviewed research reported in the English language. It is possible that there may be some degree of bias in relation to selection and publication bias. This may be particularly problematic because South Asian populations were the group of interest and therefore relevant studies reported in South Asian languages may have been excluded from the review. Furthermore, the search strategy was developed to identify studies of interest however, it is possible that some studies may have been excluded that used different terminology to that used to search the databases. There is also the possibility for selection bias in the development and utilisation of the search strategy and criteria for inclusion as only one individual conducted this. The involvement of other individuals was not feasible for this review.

6. Conclusion

The review highlights that women obtain an abortion within different personal, social, and economic circumstances. This can influence the meaning of an abortion and how others respond to women who have an abortion. The experience of an abortion appears to vary as a function of a woman's ethnicity, religious, and moral beliefs and those of others in their immediate social environment. Women's experiences of abortion are also likely to be influenced by their personal appraisals of pregnancy and motherhood. Importantly, although ethnic differences exist there are also variations in attitudes within ethnic groups. Given these issues, further research is required to explore these attitudes to abortion, in relation to personal, societal/cultural and religious systems. Furthermore, acculturation effects can be particularly significant when exploring ethnicity. This area requires further investigation as this can influence how procedures and interventions are considered which in turn, influences health-care decisions. Furthermore, it is crucial that acculturation effects are measured in health services and epidemiological research because generational differences and regional differences are likely to exist and this has the potential to impact on services and legislation.

Appendix 1- Electronic search strategies

The table below illustrates the search strategy utilised in the MedLine database. This search strategy was slightly modified but also used to search the other databases

Set	Search terms	Results
1	Termination of pregnancy AND attitude* AND Pakistan*	3
2	Termination of pregnancy AND attitude* AND India*	1
3	Termination of pregnancy AND attitude* AND Bangladesh*	0
4	Termination of pregnancy AND belief* AND Pakistan*	1
5	Termination of pregnancy AND belief* and India*	2
6	Termination of pregnancy AND belief* AND Bangladesh*	0
7	Termination of pregnancy AND perception* AND Pakistan*	2
8	Termination of pregnancy AND perception* AND India*	0
9	Termination of pregnancy AND perception* AND Bangladesh*	0
10	Termination of pregnancy AND view* AND Pakistan*	3
11	Termination of pregnancy AND view* AND India*	0
12	Termination of pregnancy AND view* AND Bangladesh*	0
13	Abortion AND attitude* AND Pakistani*	8
14	Abortion AND attitude* AND India*	4
15	Abortion AND attitude* AND Bangladesh*	2
16	Abortion AND belief* AND Pakistan*	2
17	Abortion AND belief* AND India*	3
18	Abortion AND belief* AND Bangladesh*	1
19	Abortion AND perception* and Pakistan*	4
20	Abortion AND perception* AND India*	0
21	Abortion AND perception* AND Bangladesh*	0
22	Abortion AND view* AND Pakistan*	3
23	Abortion AND view* AND India*	3
24	Abortion AND view* AND Bangladesh*	0

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Section Two: Journal Paper

“Why would you not want to accept what God has given you?”:
South Asian women’s discourse on termination of pregnancy

Running head: South Asian women's discourse on termination of pregnancy

JOURNAL PAPER TITLE PAGE

**Article for submission to the journal:
Ethnicity & Health**

**Title: 'Why would you not want to accept what God has given you?':
South Asian women's discourse on termination of pregnancy**

**Authors: Rajea S Begum, Roshan das Nair
and Saima Masud**

'Why would you not want to accept what God has given you?': South Asian women's discourse on termination of pregnancy

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Objectives. This research explored how discourse operates to produce a particular 'truth' of termination of pregnancy (ToP), and how this affects our understanding and practices related to ToP.

Design. There were two stages to this research: First, a document analysis was conducted and information was collected from health organisations in the UK. A thematic analysis was then performed scrutinising the material collected, to contextualise healthcare and legislative discourse. Second, semi-structured interviews were conducted with six South Asian women living in England. This data was then analysed using a Foucauldian discourse analysis theoretical framework.

Results. Discourses underlying religious and cultural ideas influenced how women constructed ToP, their actions and practices. The commitment to a strict reading of Islamic ethic and culture among the women was evident. These discourses are likely to have a psychological impact and influence psychological recovery following a ToP in instances where the decision to terminate goes against religious and cultural beliefs or where there is pressure from others to terminate the pregnancy.

Conclusion. Religious and cultural discourses play a central role in how women make sense of ToP. Clinicians may need to develop cultural competencies to be able and willing to engage in discussion about religious and cultural influences on decision-making in relation to ToP. This will help support women, reduce psychological distress and help improve health outcomes.

Key words. South Asian, religion, health, termination of pregnancy, abortion, discourse, Foucault

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Introduction

Termination of pregnancy (ToP) has been legal in the United Kingdom (excluding Northern Ireland) since the introduction of the Abortion Act in 1967 (amended by the Human Fertilisation and Embryology Act [1990]). Under the Act, women are able to access safe and legal ToP, provided that the termination is certified by two registered medical practitioners and meet the justifiable grounds for a termination (Department of Health [DoH, 2009]).

In 2009, the total number of terminations recorded for England and Wales was 189,100 (DoH, 2009). Of these, the majority (97%) were conducted on the grounds that continuing with the pregnancy would result in increased physical and psychological risk to women (DoH, 2009). Ethnicity data, recorded for 94% of women who had a termination in 2009, revealed that 76% identified as White, 10% as Black or Black British, and 9% as Asian or Asian British (DoH, 2009). Interestingly, in 2009 there was no increase in the rates of ToP since 2008, with the exception of Asian or Asian British group, which has increased 2% since 2005 (DoH, 2009). Moreover, the number of previous ToP has also increased by 1% since 2008 with this figure at 30% in 2009 for this ethnic group (DoH, 2009).

One explanation for this change in prevalence rate might be in part, due to an acculturation effect where changes in sexual and reproductive practices are attributable to minority groups assimilating into the dominant culture. Anwar (1998) proposes that second generation Muslims present a challenge as to how far Islamic beliefs and practices will be sustained in a non-Islamic environment, raising questions about the future identity of British Muslims.

There are challenges in using ethnicity categories as these are usually over-simplified and do not have a fixed and uncontested meaning. Within a single ethnic category there is diversity in terms of religion, history, culture, language, and migration history. For example, 'Asian' communities comprise of those who subscribe to religious beliefs (the most popular amongst them being Islam, Christianity, Hinduism, Sikhism, Jainism and Buddhism), and

those who do not have such beliefs. Also, within all religions there is no global perspective. For instance, Islam has many schools of thought, which originate in particular ways of understanding scriptural texts such as the Qur'an (see Ramadan, 2004).

Research also tends to refer to Muslims as one homogeneous group and report a global perspective of Islam despite knowing that there are many personal and cultural interpretations of any religion. Therefore, the use of simplistic categories in planning, research and health policy can be problematic, as it does not distinguish people with shared characteristics in terms of health status or needs (Rosanathan, Craig and Perkins, 2006).

Laird, Marrais and Banes (2007) explored how Islam and Muslims are positioned in health and biomedicine research and how this interacts with general cultural discourses that readers of these texts are subject to. These authors have identified several shortcomings of medical literature, commonly accessed by clinicians and researchers for information on Muslim patient populations with underlying themes implying that 'being an observant Muslim poses health risks; Muslims are negatively affected by tradition, and should adopt modernity; and that "Islam" is a problem for biomedical healthcare delivery' (p. 2425). These findings further propagate the notion of a homogenous Muslim identity and associated beliefs and practices.

Psychological effects of ToP

Several studies have explored whether a termination increases potential for psychological risk and lead women to experience an adverse psychological reaction and poor mental health. Lipp (2009) found some women are likely to experience negative psychological consequences (usually temporary) following a ToP if they have a previous history of psychiatric illness, they have a termination for medical reasons, or are pressured into making the decision. A systematic review (Bonevski and Adams, 2001) investigating psychological consequences following a ToP found that impulsivity, low self-esteem, limited social support, late-gestation termination, previous psychiatric illness and

conflict with religious or cultural beliefs predicted negative psychological consequences following a termination. Several studies in this review reported increased grief in women obtaining a termination because of foetal abnormality (e.g., Hunfeld, Wladimiroff and Passchier et al. 1994).

Research assessing the negative psychological effects of termination on women at six months and two-year follow-up found that the strongest predictor of emotional distress was pressure to have a termination (Broen, Moum, Bodtker and Ekeberg, 2005a). Broen et al. (2006) found that women undergoing a termination had poorer mental health before the event than women who had a miscarriage and that this continued until the end of the five-year follow-up period. This study also found that feelings such as grief, loss and doubt might all be present at the time of ToP.

Another study found that 10% of women who undergo a termination experience severe and on-going psychological consequences in the form of anxiety and depression (Zolese and Blacker, 1992). However, Bradshaw and Slade (2003) suggest that psychological distress following ToP is often temporary and there is a reduction in the level of reported distress over-time.

Taken together, these studies indicate that there are mixed findings about whether ToP is a significant life event that may trigger a negative psychological reaction in vulnerable people, or whether ToP is a minor life event (or not considered a life event), with minimal or temporary detrimental effects.

It must be noted however, that the quality of studies in this area varies substantially in terms of sample size, sample selection and validity of measures. Many studies do not include a comparison group and have relatively short follow-up periods; some lack theoretical grounding, and use forms of measurement that are non-standardised (Bradshaw and Slade, 2003). Most studies employ quantitative methodologies, which are not adequate for exploring the nuances of cultural and religious mediated attitudes and practices that may influence women's reported distress or

positive psychological outcomes. Further knowledge and insight into this area is required to cater positively for women with a wide diversity of beliefs and practices in a multicultural society. *[Additional research is discussed in the extended paper].*

South Asian Communities, Religion and Culture

Most studies, which have investigated attitudes towards ToP in non-white populations, have generally been conducted outside of the UK (Ahmed et al. 2008). Research conducted with South Asian communities in the UK has focused on Pakistani-Muslim communities. There are no studies with other ethnic groups and religious communities in relation to ToP in the UK.

Studies with Pakistani-Muslim communities suggest that Pakistani women hold less favourable attitudes to ToP compared with White women (Hewison et al. 2007). One study (Ahmed et al; 2008) found that the main difference between European and Pakistani groups was the role of religion in Pakistani women's decision-making in relation to ToP. Another study also suggests that religion is an important factor in decision-making in relation to ToP, but factors such as severity of condition and views of the family also play a role (Ahmed, Green and Hewison, 2006). However, Ahmed et al. (2006) conclude that decisions about ToP occur within the broader social context, in which family and religion are only two aspects.

Muslims are simultaneously members of many identity groups, but in a UK setting may wish to differentiate between religious and ethnic identity (Jacobson, 1997). Cultural practices not directly based on Islamic teachings may be open to change and sometimes rejected by Muslims themselves. However, the maintenance of religious boundaries may restrict the extent to which social change in certain areas is possible.

There is diversity in sexual health knowledge, sexual attitudes and sexual behaviours among people from a variety of different religions (Coleman and Testa, 2008). Furthermore, religious identity plays a significant role in people's

attempts to make sense of the personal illness narrative and often forms a society's orientation towards issues (Mir and Sheikh, 2010), such as ToP. Despite these findings, policy and research generally consider health inequalities in relation to ethnicity, instead of religious identity (DoH/ HM Treasury, 2002). This is problematic, because: (i) research suggests that religious and cultural beliefs can both impact on negative psychological consequences following a termination, (ii) there is a tendency to homogenise groups simply on the basis of one characteristic (e.g. ethnicity), without understanding or appreciating the nuanced nature of *living* intersecting identities.

The UK census (Office of National Statistics, 2001) found that South Asians represent the largest minority group in Britain, and that there were at least 1.6 million Muslims in Britain and that Muslims fared worse than all other religious groups in relation to self-reported poor health and self-limiting illness/disability. Muslims are an integral part of multiracial, multicultural and multi-faith Western Europe and they form the largest religious minority group in the UK (Anwar, 2008).

It is then a matter of some importance to understand and appreciate the values and beliefs of South Asians, as they are a large and influential minority group. Such understanding and appreciation is crucial to enhancing empathy, trust and respect between South Asian patients and their healthcare providers.

Purpose of Investigation

In all communities, cultural norms and religious boundaries operate to prohibit certain attitudes and behaviour and to prescribe others (Nazroo, 1997). The experience of a termination may vary as a function of women's ethnicity, culture and religious beliefs and those of others in their immediate social environment. Research exploring the nuances of these issues will develop our understanding of what factors might influence the meaning of a termination, women's understandings and reproductive decision-making processes, and

the challenges South Asian women may face when considering a ToP or following a termination. Exploring these issues will provide an important contribution to public health and enhance health professionals' awareness of religious and cultural issues whilst supporting women using culturally appropriate mechanisms.

At present, there is limited research exploring the intricate connections between faith, ethnicity and health. Research that considers the implication of this relationship for those striving to develop culturally competent and sensitive care is necessary to minimise the replication of cultural biases and prejudices that can exclude minorities, and reinforce inequalities in health outcomes and healthcare access.

Theoretical framework of this study: Foucault, power, knowledge and discourse

There are many different discourses about the concept of ToP around the world. However, within a particular time and place, a specific set of ideas will come to define socially acceptable practices (Foucault, 1972).

The concept of discourse is an important component in Foucault's theoretical arguments and to his methodology. Foucault (1981) proposes that power is essentially linked to knowledge, and discourse centers on the production and circulation of power and knowledge. He argues that particular knowledge systems convince individuals about what exists in the world. This knowledge about the world determines what individuals say and how things are constructed within it. Foucault (1981) proposes that the outcome of this is that there is space for variance in identity formation, and room to manipulate power.

Foucault (1972) has identified several discursive mechanisms to understand the way in which power/knowledge influences discourse. These mechanisms act as 'procedures of exclusion' which specify the regulatory mechanisms that operate to control, strengthen or subjugate discourse and include: division

and rejection, commentary and authorship and normalisation. *[Part two of the extended paper defines these terms and details how according to Foucault, discourse operates].*

Aims

This research uses Foucauldian theory and a social constructivist position to explore South Asian women's constructions of ToP in relation to the discourses available. Foucault's theoretical ideas (1972; 1981) are used to explore the principle that through the exclusion of certain discourses and the operation of power, certain people are allowed to silence and marginalise others while legitimising dominant discourses.

Ethics

The University of Lincoln granted ethical approval.

Inclusion Criteria

Women who identified as South Asian namely, Bangladeshi, Indian and Pakistani and who were above 18, and were conversant in English were included in the study.

Methods

From March 2011 to July 2011, six semi-structured interviews were conducted with a purposive sample of South Asian women (aged 24 to 40 years) living in England. Five women of these women self-defined their ethnicity and religion as Pakistani-Muslim and one as Indian-Hindu.

Of the sample, five women were born in UK and one woman was born in Pakistan. Of the women born in the UK, four were in full time-employment, and one was married with children. The other UK-born Pakistani woman was married with children and unemployed. The Pakistan-born woman married in Pakistan and then moved to the UK seven years ago.

Women were identified from three community centres accessed by ethnic minority populations. Posters were displayed at each centre, and staff distributed study information to women accessing the centre. Interested participants contacted the primary researcher (R.B) directly and a meeting was arranged to discuss the study and gain informed consent. Interviews were arranged with women interested in participating. This study was explained to participants in terms of ToP being an under-researched area in relation to minority populations. Also that it would be valuable to gain a better understanding of Muslim women's perspectives as this might help health professionals understand any needs that women may have.

The interview schedule developed was modified following a pilot study, which identified some problematic language-usage. The schedule included open-ended questions that asked about: personal views about ToP, cultural and religious views, and the role of significant others.

The face-to-face interviews were conducted by R.B in a community centre within the participant's locality. With the participants' consent, the interviews were audio-recorded. Interviews lasted between 46-72 minutes. Following the interview, participants were given information about free and confidential pregnancy and post-termination support service should they require assistance with any issues raised by the interview.

The recorded audio-data was transcribed verbatim by R.B using an adapted version of the Jeffersonian transcription notation system (Rapley, 2007). All data were anonymised using pseudonyms. To enhance quality assurance, the transcription of the interview was checked against the audio-file for consistency and accuracy. In addition, an audit trail consisting of detailed and accurate descriptions of the research was maintained. R.B considered the ways in which her involvement may have affected the study. This was achieved in two ways: personal reflexivity strategies involving the completion of self-reflective records and a diary examining personal goals and assumptions about the research area; and epistemological reflexivity enabling R.B to reflect on her assumptions made about knowledge and the world and

the implications of this for the research. Supervision was utilised from the other two authors (S.M and RdN) to expand R.B's frame of reference and ensure adherence to the quality criterion.

Document analysis

Prior to analysing the interview transcripts, documents produced by health organisations in England were examined. This was to characterise the healthcare and legislative discourses around ToP. Material for the document analysis was identified by sampling some of the key publications of the major reproductive health organisations in the UK. A list of organisations and key documents was drawn up by R.B and verified by S.M who has specialist interest in the topic area. This list was not intended to be completely representative and the documents were not sampled at random because this analysis was merely to serve as a starting point for investigation into this area, and for R.B to familiarise herself with some of the content and discourses produced by agencies responsible for providing health care information, some of which may have been familiar to some of the women in the sample.

Two key publications about ToP were identified: 'Abortion care: what you need to know', (Royal College of Obstetricians and Gynaecologists [RCOG], 2010). and 'Abortion: your questions answered,' (Family Planning Association [FPA], 2010). R.B performed a close reading of the material at a latent and semantic level to draw out the key themes evident using Braun and Clarke's (2006) model of thematic analysis. The following themes were identified: information about the law and ToP, where to obtain a ToP, the various medical procedures available, the risks involved and what will happen before, during and after the ToP.

In order to identify what information is produced and available for women to access, six GP surgeries situated within close proximity of the community centres identified for recruitment were approached. R.B found that of the six surgeries contacted two had the FPA publication and one had the RCOG publication available for women to access. However, three surgeries had no published information available and none of the surgeries contacted had this

information available in any other languages but English. These observations suggest that there are gaps in service provision of such information, in particular lack of information available and also a lack of appropriate language support that may disadvantage women from non-English speaking backgrounds.

Analytical framework

The data from the interviews was analysed using Berg's (2009) method of discourse analysis. Table 2 outlines the stages of this model.

Table 2: Key methodological components for doing discourse analysis
(Berg, 2009; pg. 219-220)

Stage of analysis	Description
Suspending pre-existing categories	The researcher engages in the process of reflexive analysis by examining their own position in the discourse and considering how their position helps to constitute particular understandings of the issues under analysis.
Absorbing oneself in the texts	The researcher becomes familiar with the data through the process of 'reading' and 're-reading' to identify any themes that arise in the reading of the text.
Coding themes	The researcher codes the data for specific themes. Particular attention is given to the ways that the producer and consumer of a text are positioned by the text and how objects discussed in the text are also positioned textually.
Identifying 'regimes of truth'	Discourses are dependent upon particular knowledge that specifies the validity of ideas, practices and attitudes in terms of truth/falsehood, normal/abnormal and moral/immoral. Hence, it is significant to understand the mechanisms by which a particular discourse is seen to have both validity and worth.
Identifying inconsistencies	All discourses are continuously questioned by subordinate discourses. The researcher aims to identify inconsistencies, contradictions and paradoxes in order to understand how these inconsistencies might challenge or support the dominant meaning created in a given discourse. These inconsistencies also allow for the construction of new subject positions and identities in discourse.
Identifying absent presences	Discourses are often reliant on their silences for their power. It is important for the researcher to identify these silences and consider how they operate to create and eliminate particular subjects.
Identifying social contexts	The researcher must recognise the social context within which discourses arise. This involves linking the production of the discourse with the production of key subject positions and thinking about how power operates.

Analysis and Discussion

In keeping with the structure of the model for analysis, R.B has evidenced the process by discussing how she suspended preexisting categories, absorbed herself with the data and coded themes from the data [*detail is available in the extended paper*]. The data analysis and discussion, in relation to Foucauldian ideas, is then presented.

Stage 1: Suspending pre-existing categories

Prior to analysing the data, RB attempted to examine how her own position might help to constitute particular understandings of the issues under analysis. This involved using reflexive strategies to consider how she felt towards ToP and why she chose to investigate this area. She also considered where she was positioned during the interview and how participants viewed her in terms of her gender, ethnicity and religious identity markers (e.g., her name). Following consideration of existing research R.B felt the following categories would be important to women: religion, cultural expectations, severity of conditions, stages of gestation and the view of significant others. These categories were not imposed on participants. Instead RB attempted to refrain from asking questions related to her own preexisting assumptions.

Stage 2: Absorbing oneself in the texts

RB absorbed herself in the objects of analysis. This involved becoming familiar with the transcripts, studying them thoroughly to identify particular themes that arose in examining the transcripts. RB also reflected on her style of questioning, the content of the interviews, and the rapport established.

Stage 3: Coding themes

Once RB was familiar with the objects of analysis, she coded the data for particular themes that arose in the reading of the transcripts. This reduced the data, created organisational structure and aided the analysis. These codes were discussed with other authors.

Drawing on Foucault's (1972; 1981) ideas, particular attention was given to the context, practices, perspectives and experiences of participants. The two themes that are explored in this paper are the role of religion, and community and cultural influences.

This stage also provided the opportunity for continued critical self-reflection. By reviewing the data and the connections between the codes, RB aimed to understand her own research practice, participants' representations and broader knowledge constructions.

Due to space restrictions, we only focus specifically on how religious and cultural discourses operate to construct a particular 'truth' of ToP.. *[See extended paper for an exploration of additional themes and the extended analysis and discussion section].*

Stage 4: Identifying 'regimes of truth'

Pakistani-Muslim women's knowledge of whether ToP is permitted by their religion, Islam, was derived from the Qur'an, which was viewed as the edicts of God and of divine origin. There was also reference to seeking the advice of local religious leaders with knowledge of Islamic ethics.

Islamic perspectives were regarded as the most reliable source for obtaining 'truth' and 'knowledge' and were significant in how Muslim women understood ToP. All women spoke about cultural ideas, which included reference to social norms, and the expectations of their community. These ideas appeared to stem from religion and were also important in how women understood ToP.

Prohibition

Evident in the data was a discourse about ToP being a prohibited act in Islam and circumstances when ToP would be acceptable. All Muslim women interviewed stated that they would not consider or agree with the decision to terminate because this practice was not permissible in Islam. The exception to

this would be if a woman's life was endangered by the pregnancy. Rizwana shares her thoughts on what she believes Islam says about termination:

Extract 1

“from what I know it's WRONG that's what our Islam says it's wrong to have an abortion like I said if it's a matter of life and death go ahead with it (.) but if it's NOT matter of life and death I don't think it's ALLOWED (.) I don't think it's allowed in our religion in our Islam...” (lines: 294-298).

Rizwana views ToP as a prohibited act and indicates that Islam has clear ideas about this issue. By suggesting that termination is “*WRONG*” because it goes against what religion prescribes, it serves to direct women to refrain from terminations. Therefore, the outcome could be the casting of women who seek and/or obtain termination as disobedient and sinful, not respecting what God articulates and the value of human life. Rizwana uses the word “*our*” several times, emphasising that she too belongs to and affiliates with this religion. There is a sense of group cohesiveness as Rizwana suggests that this view is shared and supported by many others, also perhaps reading that the interviewer (R.B) is a fellow Muslim, thereby co-opting her in subscribing to this view.

The extract illustrates the Foucauldian notion of ‘division and rejection’ (Foucault, 1972) where there is a separation of discourses based upon assumptions of their relative importance and alternative bodies of knowledge are dismissed. Extract 1 illustrates that only what Islam says about termination is worthy of knowing, as this discipline is the source of ‘truth’. Foucault (1981) suggests that social groups benefit from discursive power and through discourse power and knowledge operate here to convince women to construct the act of termination as prohibited.

When Rizwana uses the phrase “*what our Islam says...*” (Extract 1) she is perhaps using personification as a rhetorical figure by invoking scripture. Through Muslims viewing the Qur'an as the edicts of God, this implies that it

is understood as legitimate, authoritative and unquestionable. This extract supports Foucault's ideas of 'commentary and authorship' and illustrates how religious texts come to limit, control and inform discourse, through only allowing them access to a 'true' commentary of an issue, and in this case ToP. This discourse has productive mechanisms and may produce certain behaviours such as the repetition of normative ideas and 'common-sense' notions that are accepted as true. This has the effect of influencing others' perspectives and practices. For Foucault (1972), discourses that are preferred and legitimised operate to communicate meaning and preserve dominant ideologies.

Rizwana also shares her own views on termination, which are based on her religious understandings of ToP being a prohibited act:

Extract 2

"I think the women that do have abortions (.) I think that firstly they should THINK what they are about to do its like KILLING A CHILD...like killing a child you're killing your OWN child and I think it's really really wrong you know (.) and I think they need to think" (lines: 67-70).

Rizwana suggests that women's actions are more than simply terminating a foetus. Rizwana indicates that some women may not view the foetus as a human life and therefore, may feel that a termination is justified. By constructing the termination as a "killing" and the object of this crime a "CHILD" and "your OWN child", she constructs ToP as an immoral act. Rizwana personalises the child as something belonging to the mother and there is suggestion that it is a mother's duty to take care of her child and not cause them harm. Rizwana appears to sit in judgement here (*'it's really really wrong'*) and the emphasis is on urging women to think about their action. There is suggestion that women have not thought through their decisions (with her repeated use of the word "*think*"), which constitutes termination as unacceptable practice.

All Pakistani-Muslim participants identified with the discourses derived from a dominant interpretation of the Qur'an rather than discourses produced by healthcare organisations or legislation. Consequently, these women did not articulate the social circumstances within which ideas about termination is produced, circulated and maintained. This acts to dismiss and exclude alternative perspectives and highlights that some discourses are given more value. Foucault (1972) proposes that the exclusion of particular discourses permits the silencing and marginalising of others, ensuring continuity of the existing power structures where women privilege dominant interpretations of the Qur'an above alternative perspectives.

In contrast, to Pakistani-Muslim participants who viewed religious discourse as central to how ToP was constructed, one participant, Meena who described herself as an Indian and a non-practicing Hindu did not identify with a religious discourse. For Meena, there was limited internal struggle with religion evident. Meena stated:

Extract 3

"...in any religion or just erm (.) and just as a person ((laughs)) you're not suppose to kill people (.) and technically you are killing a baby... I guess if I was religious then I'd think that's completely wrong erm (.) but I'm not and I understand that (.) life isn't always black and white" (lines: 229-233).

Meena recognises that in all religions (and also morally), terminations are viewed as wrong because *"you're not suppose to kill people."* Meena laughs whilst saying this perhaps suggesting that the idea is absurd, and her use of the term *"technically"* suggests detail and exactness illustrating that this perspective is a focused and restricted view. Meena suggests that those who are *"religious"* view terminations as *"completely wrong."* However, Meena appears to reject the idea of viewing terminations as *"killing a baby"* through implying that religion is *"black and white"* and that life cannot always be seen in this way. Meena's views suggest that the maintenance of religious boundaries appears to restrict the degree to which social change is possible.

According to Foucault (1972) a network of interactions among several sectors aside from religion, act to shape Meena's knowledge. For Foucault, knowledge is created as a product of complex interactions among struggling and competing sectors. Foucault (1972) posits that individuals who are able to participate in the numerous discourses that influence society is proportionate to the amount of power that individual holds.

Circumstances of acceptance

Women were asked if there were any circumstances where termination may be acceptable (other than if the life of the mother was endangered). Some women referred to a "grey area" where, it may be permissible to obtain a ToP. Tasleem reported:

Extract 4

"... there's sort of a grey area is if the child was you know at a risk of having disabilities or you know mental or physical problems later on (.)... then the other thing I suppose is (.) rape and things like that..." (lines: 280-283).

There appears to be space for consideration of personal circumstances when making this decision. Extract 4 is suggestive of a 'loophole' that perhaps produces ambiguity in the certainty of terminating a pregnancy in these circumstances in Islam. Tasleem appears uncertain ("*I suppose*") of the exact circumstances under which a termination may be permissible. However, it is also possible that this area is seen as taboo and is therefore not openly spoken about. Her use of language such as "*you know*" and "*things like that*" may represent an attempt to avoid speaking about the emotional consequences for women.

Tasleem referred to a "grey area" however interestingly, all participants reported that they personally would not consider a termination for these reasons. It is important to contemplate where women's knowledge and understanding is derived from. In Islam it is usually men who interpret the

Qur'an (i.e. Imams). The Qur'an states, "*take not life which Allah (God) has made sacred*" (Qur'an 6:151). Although the Qur'an does not explicitly mention termination (Syed, 2009) religious figures can interpret this in many ways. If the Qur'an is interpreted where terminations are viewed as prohibited, women may want to be perceived as remaining obedient to their interpretation and consequently oppose alternative views.

Extract 4 illustrates that where there is uncertainty, dominant discourses play a key role in the social construction of knowledge, and is produced by effects of power and spoken of in relation to 'truth' (Foucault, 1972). The outcome of this is the maintenance of dominant discourses where truth is largely a patriarchal dominant interpretation of the Qur'an.

There was indication that women might be hesitant in making decisions, and seek dominant interpretations of the Qur'an. Zainab invokes the notion of God as the giver of children and a gift that must be graciously accepted (see extract 5). This suggests that women do not have the freedom to make a decision to terminate and Zainab resists any alternative views that would suggest that ToP might be permissible act.

Extract 5

"...if a child has been given to you that has an illness then you should ACCEPT THAT (.) if (.) if (.) it's gonna cause you harm (.) then (.) I (.) I ASSUME my religion DOES SAY that you can have an abortion in that respect (.) so I would go back to my (.) erm you know (.) Islamic teacher or scholar or whatever to find out what the (.) what the right procedure should be in that instance I wouldn't just (.) JUST for my own happiness (.) and my OWN relief (.) get RID of a child because he has an illness (.) I just couldn't do that" (lines: 147-155).

The phrase "*I ASSUME*" suggests uncertainty of what is allowed and there is repetition and hesitation evident in Zainab's speech. She also uses the imperative grammatical mood ("*you should*") and suggests there is a "*right*"

procedure", indicating there is no space for personal preferences (again seen later in relation to her "*own happiness*" and "*my OWN relief*"). Also, by deferring her decision to other sources of knowledge that can be consulted for guidance, she implies that importance should be given to religious figures and that their views should be sought. Zainab progresses from being uncertain to suggesting that the way to be certain is through seeking advice from religious figures. Furthermore, the use of the phrase "*get RID of*", while suggestive of termination, also invokes a sense of unpleasantness and burdensome, something to be disposed of. She also shifts from viewing the pregnancy as "*a child*" to a gendered child ("*he*"), which perhaps attempts to personify the child, while also indicating the dominant cultural value of males in South Asian Muslim societies (see Extract 12).

Zainab recognises the physical harm that can be caused by some pregnancies but does not articulate the possibility of psychological/emotional harm, perhaps because these factors are not viewed as significant and/or culturally acceptable.

Zainab construes termination as immoral practice and she personalises the scenario to herself by saying that she could not "*get RID of a child*" if a child has an "*illness*". She emphasises that there has already been consideration given in the Qur'an for when it is acceptable to terminate a pregnancy.

Views which are circulated and maintained reinforce religious ideas and have the impact of producing a 'common-sense' discourse, and conformity to the dominant religious discourse that are present amongst some Muslims in relation to ToP. Consequently, women might be hesitant in sharing an alternative view, because they fear being perceived as resisting religious ideas, which are viewed by many as a 'truthful' and 'factual' source of knowledge. Scriptural texts such as the Qur'an are viewed as the edicts of God and therefore, to question it, may be seen as challenging the edicts of God. These dominant discourses have the effect of constraining women's actions and ensuring women conform to normative standards eliminating individual agency.

Deferment of responsibility to God

From the data, it appeared that the reasons for the occurrence of challenging life-events was attributed to God and no other source of knowledge were accepted. Zainab reported:

Extract 6

“...if a child was gonna have Down’s syndrome or something like that then I (.) I feel that (.) GOD has (.) you know (.) that’s what god has prescribed for you so you should live with that CHALLENGE in your life why (.) erm (.) why would you not want to (.) NOT accept what god has given you....” (lines: 54-58).

Through accounting for the illness in this way, Zainab minimises the amount of control that she feels she has in decisions, which acts to reduce her sense of responsibility instead, deferring this responsibility to God. The words “prescribed”, and “*you should*” are imperative and suggest that raising a child with a disability is what God had intended and so women should not go against that wish. Also, although Zainab uses the word “CHALLENGE” she does not articulate what this could consist of, such as the difficulties of raising a child with disabilities and the impact that the illness would have on that child. In addition, the phrase “*why would not want to (.) NOT accept what god has given you...*” illustrates that Zainab does not consider alternative views.

There is an abandonment of power where women do not question or resist the dominant discourse present. Instead, there is evidence of submission and wilful adherence derived from an acceptance of God having responsibility.

A powerful discursive strategy in operation is ‘normalisation’. Extracts 1, 2, 5 and 6 convey messages about the norm and suggests that women have not been granted the power to question what God has given. The extracts also suggest how women should think and respond which helps to reject alternative views. Women are positioned to internalise this ‘dominant’ discourse as a normative standard and there are expectations and pressures for Muslim women to conform to these views. This demolishes autonomy and

instead produces homogeneity through processes of comparison and differentiation.

During the interviews, participants spoke about being rewarded by God in the present and the after-life. Hanifa spoke about losing her first child and understood this as God having this loss destined for her. Hanifa later had a healthy child and she believed that this was because she had “*HOPE*” in God:

Extract 7

“...Alhamdulillah (praise to God) I’m ok (.) I have HOPE that God give me another baby and look...” (lines: 268-269).

Similarly, Zainab spoke about being rewarded for raising a child with a disability:

Extract 8

“...if you BELIEVE in god and religion and all that sort of thing then hopefully you’ll be REWARDED for that in your AFTERLIFE” (lines: 59-61).

Both Zainab and Hanifa demonstrate an external locus of control where they believe that God controls and determines events such as pregnancies, the loss of a child or having an abnormal foetus with the risk of the child being born with disabilities. When women feel events are outside of their control, women may be placed in a position of powerlessness. In Zainab’s case, even her trust in God appears hedged, in her use of the word “*hopefully*,” implies that what she has is hope, not a certainty.

Extracts 6 and 8 also suggest that raising a child with a disability is a challenge of faith and an opportunity to demonstrate strength when faced with adversity. Zainab and Hanifa share ideas of reward and afterlife and suggest a shared understanding of events amongst Muslims, which acts to strengthen dominant discourses. These extracts also imply that if women did choose to

terminate a pregnancy then they would be punished for their actions, as they would *“NOT accept what god has given”* them (extract 6). The punishments for going against God’s wishes is not articulated but can serve to instil fear and facilitate conformity to perceived acceptable practice.

The perspectives shared in the interviews highlight that Pakistani-Muslim women regulate themselves through drawing upon ‘regimes of truth’ underlying religious perspectives. These discourses have regulatory intentions and result in regulatory outcomes. Foucault (1976) proposes that individuals conform to a dominant discourse because knowledge is ‘constructed’ by the power inscribed in discursive practices. It is evident that scriptural texts such as the Qur’an, and people’s shared understandings, stemming from phallocentric interpretations, limit and control the discourse of women through only permitting them access to a ‘true’ commentary of an issue. For example, the Quran is mandatory reading for Muslims and ostensibly seen as not subject to interpretation. Foucault (1972) proposes that the disciplines (e.g. Islamic perspectives) are a system of control for the production of discourse. To belong to this discipline, people must refer to a certain body of theory. The findings illustrate, as Foucault (1972) posits, that disciplines are responsible for not only the generation of discourse but also the prohibition of certain other discourses.

Community influences

When speaking about the decision to terminate a pregnancy due to the risk of the child being born with a disability, women reported that the community would have difficulty understanding this decision for reasons founded upon religion. Tasleem highlights how cultural norms (that the community adopts) are enmeshed with religious ideas and both are accepted as ‘truthful’ sources of knowledge and act as a powerful means for social control:

Extract 9

“...I think for a lot of people (.) they see you know they see things happen from GOD (.) and you know if that’s come from god then you should deal with it (.) erm and I can imagine some people’s response would be that in the community as well (lines: 332- 336).... ‘there would be certain people in the community who would you know (.) be completely against it and obviously they’d be perhaps (.) a backlash towards it as well...” (lines: 340-342).

Tasleem reports that some people in the community would be “*completely against*” terminations, which suggest that such decisions, would not be understood and supported by many people. The usage of the term “*backlash*” highlights a strong negative reaction that women whose actions go against the community’s religious beliefs could expect. These ideas can create fear and function to prevent women from considering a termination, and conforming to the dominant view. Extract 8 illustrates that cultural norms are based upon religious ideas, and how dominant discourses are strengthened through being enmeshed with other discourses.

Although Meena did not identify with a religious discourse she did with a cultural discourse. There was a shared struggle evident amongst participants in relation to repercussions within the community for both Muslim and Hindu participants.

Meena spoke about how the community would react to women terminating a pregnancy:

Extract 10:

“They’d just look down on you it would be SHAMEFUL” (line: 136).

The extract illustrates how people will react and the use of the word “*SHAMEFUL*” illustrates a meaning of judgement attached to terminations and that women are made to feel something for their actions. As a consequence

women might feel embarrassed or humiliated because of how a termination is perceived. Therefore, women who consider a termination may be vulnerable because of the community favouring 'dominant' discourses where ideas define socially accepted practices.

In summary, the 'regimes of truth' identified illustrate that taken for granted sets of ideas about who and what exists in the world help to impose bounds beyond which it is often very hard to reason and behave. Discourses can have a profound and powerful effect on people's beliefs and practices. Individual subjectivities constituted in power relations and dominant discourses can make individuals sightless to the possibilities of alternative positions and subjugate them to normative standards.

Stage 5: Identifying inconsistencies

Foucault (1972) understood dominant or 'common-sense' understandings as discursive structures. He proposed that while discursive structures may appear eternal, fixed, and natural because they are embedded within different social networks they are fragile and continually ruptured. Hence, there are always possibilities for meanings, attitudes, and practices to change to be challenged.

Women indicated that religious and cultural discourses could operate to prevent women obtaining a ToP. However, there was discussion of alternative discourses being more influential in functioning to pressure women to have a termination. Zuleka, a GP, shared her experiences:

Extract 11

"...a girl had become pregnant she was still fairly young and erm (.) the mum had been (.) was aware of it she wasn't married she had an Islamic background (.) so the fact that she had sexual intercourse before marriage you know (.) that was gonna set off a whole new erm (.) whole new issue with the community so it was the mother that had brought her in for the termination" (lines: 384- 389).

Pakistani-Muslim participants reported that Islam has guidance on when it is acceptable to terminate a pregnancy. However, in circumstances where premarital sex has taken place, Zuleka reported that families terminate the pregnancy in secrecy. These actions imply that there are fears of stigmatisation and social exclusion that may result if the pregnancy is not terminated, even if this act itself is proscribed by their religion, thereby creating a hierarchy of ills and repercussions.

Extract 11 indicates that there appears to be a conflict of people needing to decide which of the two evils is greater: others' knowledge of a woman's ToP or premarital sex. This forces people to choose which act, if it became public, would have the worst repercussions for the woman and the *izzat* (honour) of her family. This extract also illustrates that dominant discourses prohibiting terminations are disregarded in favour of a pre-marital sex discourse perhaps, because the consequences are far greater and immediate in this life rather than the punishment from God in the life after.

Zuleka spoke about family members pressurising unmarried women to obtain a termination:

Extract 12

"I think families play a big part...I've certainly seen terminations go ahead (.) as a result of family members" (lines 376-377).

Islam forbids premarital sex therefore women might be labelled with negatively valued concepts, which may have implications for the family. Extract 12 implies that the family appears to pressure unmarried women to terminate a pregnancy, despite these actions being inconsistent with the family's religious beliefs. This perhaps occurs in response to fear of the community's reactions, which is more influential than religious discourse prohibiting terminations.

Extracts 11 and 12 illustrate that people make distinctions between life on earth and life after death. Although both sins are problematic in the afterlife, ToP will at least not alienate people from their communities if kept secret, and therefore be seen by the family, perhaps as the lesser of two evils. Terminations can be kept hidden, pregnancies cannot.

Foucault (1972) argues discourses that are preferred mobilise meaning and maintain dominant ideologies. Dominant discourses are perceived as normative standards, which operate to create conformity (Foucault, 1972). Non-conformity challenges social practices, structures and power relationships (Burr, 1995). Extract 12 suggests that women take on the role of subjugating themselves through the process of being evaluated and judged in comparison to social norms. Through participation in the social environment women come to internalise normative standards, which work powerfully to produce conformity to discourses which are most influential (Foucault, 1972). In this case, pre-marital sex discourse is more influential as it is perceived as having greater consequences. Hence, women feel pressured to terminate in these circumstances.

Although a discourse prohibiting terminations was evident, Rizwana reported that there were additional circumstances where women would consider a ToP:

Extract 13

“...some women... their husband wants a BOY right and erm (.) they’ve said like if you don’t have a boy this time (.) we’re gonna you know (.) obviously that child’s not gonna be born (.) and then obviously when women go to the doctors the first thing they want to know is if it’s a boy or girl don’t they and if they know it’s a girl what do they do (.) they’ll go and have an abortion” (lines: 76-82).

There is importance attached to the “*husband*” figure and what he “*wants*” and an indication of pressure to please him. The statement “*if you don’t have a boy this time*” suggests that the woman is responsible for achieving the

desired outcome. Reference to “*abortion*” is deferred in talk and instead Rizwana uses the phrases “*you know*” and “*don’t they*” to co-opt the interviewer into a shared/common discourse reflecting cultural ideas and experiences.

Extract 13 illustrates that there are occasions in the conflicting discursive field where women engage in practices, in which dominant discourses are challenged. Rizwana suggests that this challenge might occur in instances where women face pressures from their husband, to conceive a male gendered child. In these kinds of instances, Foucault (1972) posits that knowledge is created as a product of complex interactions among struggling and competing sectors. The amount of power an individual holds is directly related to their ability to engage in various dominant discourses that shapes society. In this case, there may be cultural norms steering decisions where there is a prevalent discourse of the community preferring a male child. This practice challenges the existing discursive structure where common-sense understandings of terminations being prohibited are disregarded.

Stage 6: Identifying absent presences

Absence of challenge to patriarchy

Pakistani-Muslim participants reported that the primary source of knowledge about their religion is the Qur’an - seen as the edicts of God and not containing errors, absences or contradiction. These participants indicated that in Islam, religious leaders, scholars and mosque Imam’s, all of who are men, advise on personal matters propagating patriarchal views. However, the influence of patriarchy on the interpretations of the Qur’an was not articulated during the interviews. Pakistani-Muslim women appeared to accept and articulate the rules enforced by men without much resistance to patriarchy.

ToP is a sensitive and personal matter and the requirement of seeking advice from men and men defining women’s practice may seem inappropriate in gendered and patriarchal Islamic societies. Zainab (see extract 5) referred to seeking the advice of an “*Islamic teacher or scholar*” about the “*right*

procedure". The right to women having the control over their own fertility seems to be under threat by these religious figures who may coerce women into motherhood through influencing women's reading of religious texts and reinforcing dominant discourse.

Absence of emotions

Throughout the interviews all participants indicated that women experience challenges, judgement and fear, all of which have the potential to produce distress. However, the psychological or emotional impact on women was not articulated. This is significant, as women may not feel able to talk about the feelings that they are experiencing because their suffering appears to be ignored. This has the potential to cause women pain. *[see extended analysis and discussion section for further evidence to support these findings and additional absent presences]*.

Stage 7: Identifying social contexts

Pakistani-Muslim women's beliefs and practices were predominately influenced by the Qur'an, male religious figures, women's husbands and families, and the community they identified with. Women tended to view themselves as submissive recipients of this discourse and this produced subject positions for women, which they identified with, without recognising their own role in propagating the very discourses that serve to restrain their choices and freedoms.

All Pakistani-Muslim participants took the subject position of being a 'Muslim' and identified as 'belonging' to that position through adopting a commitment entailing a view of ToP commensurate with that membership category. Through the use of this position, women cited many reasons why pregnancies should not be terminated. These ideas were portrayed from the subject of a 'Muslim' and evoked ideas that ToP was sinful practice and conjured feelings of shame, guilt, and regret for Muslim women considering or obtaining a ToP. By subscribing to discourse against ToP, participants also adopted the position of being a 'good Muslim', as someone who upheld the status quo.

All women also took up the subject position of being a 'community member'. Women reported living in close-knit communities where ideas about termination are shared and circulated. Women indicated that the community they belong to produces pressure to conform and any contradictions to the dominant view are not culturally shared.

These findings suggest that discourse has a productive aspect to it (Foucault, 1972). Not only does it prevent women from terminating pregnancies, it also produces certain behaviours, such as conforming to the dominant view. This indicates that the social contexts within which discourses arise are important and through the circulation of power and knowledge people adopt subject positions usually consistent with the dominant view.

Findings summary

This study highlights that Pakistani-Muslim women considered reference to Islam an appropriate response when considering a termination but also, cultural values were significant amongst all women. Discourses prohibiting terminations and pre-marital sex was influential and provided a traditional script for women. These findings illustrate how discourse produces effects discursively and through practice which influences the way these women understand, experience and respond to ToP.

Implications, limitations and future research

The findings of this study provide a firmer understanding of the complexities of the relationship between ethnicity, culture, religion and ToP, and recognises the need to understand both ethnic and religious group membership when considering health implications. Religion and culture operate as an important foundation for how women understand ToP and there are causes and consequences of such affiliations.

All participants identified with ethnic and religious categories. The findings of this study suggest that it is not simply the mere affiliation with a category that

is important but also the degree of investment (emotional, behavioural, social) with the category, which influences attitudes, beliefs and practices. For example, there are those who subscribe to a religious framework (e.g. Rizwana) and those who identify but do not subscribe (e.g. Meena). In addition, South Asian women may subscribe to a particular doctrine but this intergroup is not appreciated within the view of literature. Therefore, typically, health professionals when viewing a religion rely upon one model of a particular religion but even within one sect there is heterogeneity. These findings highlight that health professionals need to recognise these distinctions to help determine how women view reproductive health issues rather than, the mere labelling of self-identify with a religious or ethnic category.

This study supports existing research, which suggests that women considering a ToP might be at risk of experiencing negative psychological consequences if this conflicts with their religious and cultural beliefs (Bonevski and Adams, 2001), there is limited social support available (Broen et al. 2005a) or they are pressured by their partner to terminate the pregnancy (Lipp, 2009). This study also suggests that South Asian communities may be a source of negative attitudes and discrimination towards women who consider or obtain a ToP, or engage in premarital sex, both of which can result in social exclusion. Hence, women who find themselves having transgressed their community moral codes might be at increased risk of emotional distress and may benefit from psychological support, which recognises these complexities of membership, alienation, and expulsion, prior to, or following a ToP.

At face value the findings of this study suggest that it may be difficult for professionals to work with these women. However, the findings of this study indicates that there are occasions in the conflicting discursive field where women engage in practices in which dominant discourses are challenged. There were examples of challenges to patriarchal views and violation of the moral codes of the community. Women reported that these actions had negative emotional and social consequences. These findings raise questions

about the accessibility of current services and the competence of professionals working with these women.

Studies indicate that healthcare professionals are not comfortable discussing religion and spirituality (e.g. White, 2009) and a large proportion of graduate and post-graduate psychology programmes exclude spirituality and religion during professional training (Plante, 2007). Hence, it is likely that psychology professionals/clinicians do not develop adequate competence to work with religious and spiritual clients.

These findings have significant implications for how the health of South Asians is managed and for delivery of health services. This study suggests that professionals (including clinical psychologists) should be mindful of affiliations and belief systems women hold and be aware of power differentials and agency among women. Training clinical psychologists to understand the essential principles of a religion, on which attitudes, cultural norms and practices are based upon, may help understand reproductive health decisions better, and perhaps minimise the replication of cultural biases and prejudices that can exclude minorities and reinforce inequalities in health outcomes and health access.

To achieve this, it is necessary for clinical psychologists to engage with South Asian grass-root organisations to facilitate conversations about ToP and reproductive health. Grass-root organisations can act as advocates for South Asian women and help to train Clinical Psychologists to deal with cultural and religious sensitivities. Clinical psychologists can filter this training down to clinical healthcare staff to improve cultural and religious awareness.

Grass-roots work needs to be done with women to engage them in challenging patriarchy and promoting critical thinking, but also, work needs to be done with men who, as demonstrated in this study have a large influence in women's health. Therefore, working with men and religious leaders to highlight the physical and psychological damage that can be caused to women if their ToP's are regarded unfavourably and are stigmatised, might

help.

The findings of this study also suggest that decisions are individually based and occur in the context of broader social relationships. Therefore, interventions should be tailored to meet the needs of women (with sensitivity to the individual's religious and cultural beliefs) and where possible, these women should be worked with individually. This work needs to be done in a safe place, which allows women to organise and develop their thoughts and feelings about ToP and reproductive health away from patriarchal views. This space will also allow women to label and vocalise their challenges, struggles and hardship.

The document analysis highlighted that there was lack of information available about ToP and also lack of appropriate language support. Hence, accessibility to information is an issue that also needs to be considered.

A potential limitation of this study is that we did not aim to interview women who had experienced a ToP. Therefore, discourses women draw upon following personal experiences of a ToP may vary, perhaps, illustrating some resistance to dominant discourses. Nevertheless, the study highlights the challenges women face prior to or following a termination specifically, the pressures women face and the likelihood of limited social support being available. Future research exploring whether women access support groups prior to or following a termination may be beneficial. There is also a need to investigate the potential benefits of having a professional from the same ethnic background who can understand cultural and religious circumstances and issues of these women, but also balancing this with issues of perceived threats to confidentiality because of a shared social location and ethnic or religious affiliation.

Key messages

- (1) Religious and cultural discourses play a central role in South Asian's women's attempts to make sense of ToP.
- (2) South Asian women who find themselves having transgressed their community moral codes might be at increased risk of emotional distress and may benefit from psychological support, which recognises these complexities of membership, alienation, and expulsion, prior to, or following a ToP.
- (3) An appreciation of religious ethic and culture surrounding reproductive health issues, such as ToP, can help health professionals in the challenging role of delivering care in a manner that is appropriate and culturally sensitive.

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Section 3: Extended Paper

Part One: Extended background

1. Section Introduction:

In this section the researcher draws on literature that has informed current understandings of termination of pregnancy (ToP) to set the context for this research. First, ToP is defined and the interventions that are available to women seeking a termination are explored. Second, the Abortion Act (1967) is outlined because it is important to understand the legislative criteria for obtaining a termination. Third, the prevalence of ToP is examined. Fourth, the researcher draws on psychological literature and considers the importance of this area in psychology. Fifth, literature on Islamic perspectives on termination is presented. Finally, the purposes and the aims of this research are specified.

Definition, procedures and legislation

ToP ensures that the pregnancy does not continue, by voluntary cessation of the foetal development. Intervention can take the form of medical and surgical methods, and is dependent on the duration of gestation and other circumstances relating to the individual woman (Department of Health [DoH], 2009). The main medical method involves the use of the drug Mifegyne. The surgical methods commonly used include: vacuum aspiration and dilatation and evacuation (DoH, 2009).

ToP has been legal in the United Kingdom (excluding Northern Ireland) since the introduction of the Abortion Act in 1967 (amended by the Human Fertilisation and Embryology Act [1990]). Under the act, women are able to access safe and legal terminations provided that it is certified by two registered medical practitioners and are justifiable (DoH, 2009). The table below highlights the grounds for justifying a termination.

Table 1: Grounds for ToP (adapted from DoH, 2009)

A	Continuing with the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy was terminated (Abortion Act, 1967, as amended, section 1(1)(c))
B	The termination is necessary to prevent severe permanent injury to the physical or mental health of the pregnant woman (section 1(1)(b))
C	The pregnancy has not exceeded its twenty-fourth week and continuing with the pregnancy would involve risk, greater than if the pregnancy was terminated, of injury to the physical or mental health of the pregnant woman (section 1(1)(a))
D	The pregnancy has not exceeded its twenty-fourth week and the continuance of the pregnancy would involve risk, greater than if the pregnancy was terminated, of injury to the physical or mental health of any existing children of the family of the pregnant woman (section 1(1)(a))
E	There is a substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped (section 1(1)(d))
	Or in an emergency, certified by the operating practitioner as immediately necessary:
F	To save the life of the pregnant woman (section 1(4))
G	To prevent severe permanent injury to the physical or mental health of the pregnant woman (section 1 (4))

Prevalence

The rates of ToP have steadily risen since 1992, with the exception of the last two years where there has been a small reduction in the overall number recorded (DoH, 2009). In 2009, the total number of terminations recorded for residents of England and Wales was 189,100 in comparison with 195,286 in 2008, a fall of 3.2%. In 2009 the National Health Service (NHS) funded 94% of these terminations. The remaining 6% was funded privately (DoH, 2009).

The DoH (2009) indicates that the majority (97%) of terminations in 2009 were undertaken under ground C, where continuing with the pregnancy would result in increased physical or psychological risk to the pregnant woman. One-percent were carried out in relation to ground D and a further one-percent were carried out under ground E. Together, grounds A and B accounted for less than five-percent of terminations. Of these terminations, the majority were performed under thirteen weeks (91%). Approximately 75% percent were under ten weeks and a further 16% at ten to twelve weeks. In 2008 these figures were 73%, 17% and 10% respectively (DoH, 2008). This highlights an increase in the number of terminations that are performed under ten weeks.

Of particular significance is that the termination rate in 2009 was highest for women aged 19, 20 and 21, at 33 per 1,000. Compared with 2008 where rates for women in most age categories were lower. Single women carried out 84% of terminations in 2009. This figure has gradually risen from 75% since 2000. In 2009 a high proportion (34%) of women obtaining a termination had had one or more previous terminations (DoH, 2009). Of these, 25% of terminations were repeat terminations in women under the age of 25 years.

These findings suggest that most terminations are obtained where continuation with the pregnancy would result in increased physical or psychological risk to the pregnant woman. In addition, these findings highlight there has been an increase in terminations performed earlier in the gestation period. However, termination rates for some age groups are higher than others with single women carrying out a large proportion of terminations. Furthermore, rates of previous terminations have also increased and women under the age of 25 years seek a quarter of these repeat terminations.

Ethnicity

Since 2002 the revised HSA4 form (completed when women undergo a termination) allowed women to self-report their ethnicity. Ethnicity was self-reported and recorded on 94% of the forms received for a termination in 2009. 76% were reported as White, 10% as Black or Black British and 9% as Asian

or Asian British.

This research is particularly interested in women who define themselves as South Asian therefore, prevalence rates for this group are explored in greater detail. The health sector in England generally includes Indian, Pakistani and Bangladeshi people under the homogenous ethnic category 'Asian' or 'Asian British'. This category can be problematic because it does not have a fixed and uncontested meaning. The category is broad and comprises of people with backgrounds from many different countries with significantly different cultures and beliefs. Even within a single ethnic group there is diversity in terms of migration history, language, culture, and religion. The use of this category in planning and research can be particularly problematic, as it does not discriminate people with shared characteristics in terms of health status or needs (Rosanathan, Craig & Perkins, 2006). Hence, the needs of groups within this category may be masked or there may be an inappropriate targeting of services. The 'Asian' category does however, provide an avenue to propose resources and facilitate research into the health status of the diverse 'Asian' population (Rosanathan, Craig & Perkins, 2006). The category 'South Asian' was used in this study because it is increasingly used in the health sector in England and is prevalent in common discourse and therefore, it is likely that this category will continue to be commonly used.

As previously mentioned termination rates for Asian or Asian British women in 2009 was nine-percent. This figure has increased two-percent since 2005. Furthermore, the rate for previous terminations for this group in 2009 was 30%. This figure is the highest recorded for this ethnic group since the recoding of ethnicity (up one-percent since 2008). Table two illustrates the number of legal terminations that took place in 2009 by women who identified as 'Asian.'

It is important to note that in 2009 there was no increase in the rates of termination since 2008, with the exception of Asian or Asian British women, which have continued to slowly rise. These figures are highest for women aged 20-34 years; this is consistent with women of other ethnic groups. These

findings suggest that the situation is complex and there is interplay of many factors, which have the potential to influence women's decision to terminate. One possible explanation for this increase in prevalence rates might be partly due to an acculturation effect where changes in sexual practices are attributable to minority groups assimilating into the dominant culture. For instance, it has been suggested that second generation Muslims present a challenge as to how far beliefs and practices will be maintained in a non-Islamic environment that raises questions about the future identity of British Muslims (Anwar, 1998).

Table 2: Legal terminations by Asian ethnicity and age in 2009
(Adapted from DoH, 2009)

Category	All ages	Under 20	20-34	35 and over
Asian or Asian British- Indian	5,361	347	4,107	907
Asian or Asian British- Pakistani	3,218	335	2,329	554
Asian or Asian British- Bangladeshi	1,618	216	1,193	209
Asian- Any other Asian background	5,106	464	3,611	1,031

The context of the construct ToP in England has been outlined. Next, psychological literature exploring ToP will be discussed.

Psychological effects

There is a debate in literature about whether ToP is a significant life event that may trigger a negative psychological reaction in vulnerable people, or whether termination is a minor life event. In this respect, the risk of negative psychological reactions or poor mental health following a termination may be comparable to, or perhaps better than, continuing with the unwanted

pregnancy until the birth (American Psychological Association [APA] Task Force on Mental Health and Abortion, 2008).

Studies have investigated whether terminations increase potential for psychological risk and lead women to experience an adverse psychological reaction and poor mental health. Broen et al. (2006) found feelings such as grief, loss and doubt may all be present at the time of the termination. Other studies suggest that the physical effects of ToP are minimal (e.g. Rorbye, Norgaard & Nilas, 2005). However, if we look more closely at the literature, the potential psychological effect is multi-faceted.

Studies examining factors influencing negative psychological consequences suggest some women are at greater risk than others. A recent review (Lipp, 2009) found that women were more likely to experience negative psychological consequences following a termination if they had a previous history of psychiatric illness including depression; they had a termination for medical reasons, (such as foetal abnormality); or were pressured into making the decision. However, such negative psychological consequences were often temporary.

Another review (Bonevski & Adams, 2001) summarised international literature investigating psychological consequences following a ToP between 1970 and 2000. They found that overall in healthy women legal and voluntary ToP has neither short-term nor long-term psychological consequences. Impulsivity, low-self esteem, limited social support, late-gestation termination, previous psychiatric illness and conflict with religious or cultural beliefs appear to predict negative psychological consequences following a termination. A number of studies included in the review reported increased grief in women having a termination because of foetal abnormality (e.g. Hunfeld et al. 1994). However, Bonevski & Adams (2001) noted that the quality of these studies varied substantially in terms of sample size, sample selection and validity of measures.

Broen, Moum, Bodtker and Ekeberg (2005a) assessed the negative psychological effects of termination on women at six months and two years follow-up. They found that the strongest predictor of emotional distress was pressure from a male partner to have a termination. In a later study (2006) these authors found that women undergoing a termination had poorer mental health before the event than women who had a miscarriage and this continued until the end of the five-year follow-up period. These findings suggest that the process of undergoing a termination can be more distressing than a miscarriage, and produce poorer mental health outcomes. Zolese and Blacker (1992) suggest that 10% of women who undergo a termination experience severe and on-going psychological consequences in the form of anxiety and depression. Similarly, Bradshaw and Slade (2003) conducted a review of studies investigating women's emotional experiences following a termination. Prior to having the termination women reported experiencing significant levels of anxiety (40-45%) and around 20% reported experiencing depressive symptoms. One month following the termination they found a reduction in women's reported levels of depression, general distress and anxiety although this reduction varied amongst studies. This suggests that psychological distress following a termination is often temporary and there is also a reduction in the level of reported distress over-time.

Pre-existing depression and subsequent regret following termination may indicate common risk factors such as depression, suicide attempts or harmful outcomes of termination on mental health (Thorp, Hartmann & Shadigian, 2002). The authors recommend that women considering a termination should be cautioned about an increased risk of self-harm or suicide. However, Lipp (2009) argues that this may be ineffective during this sensitive time. It is important to note that the majority of the studies included in the Bonevski and Adams (2001) review were empirical studies involving interviews or questionnaires, while several of Thorp et al's (2002) studies were record-linkage studies (linking existing data sets together), with more limited capacity to examine causality (Lipp, 2009).

Research investigating positive outcomes following a termination has found that women report experiencing relief (Major et al. 2000). However, the ethnicity of women was not specified in this study and it is likely that there will be diversity in women's experiences. A longitudinal study followed 13,000 UK women over 8-11 years (Gilchrist, Hannaford, Frank & Kay, 1995) and found that psychological consequences were no higher following termination than childbirth in women with no psychiatric history. Similarly, in the long-term, Bradshaw and Slade (2003) report that, over 10 years, women who had terminations did not have poorer psychological health than women who gave birth to wanted or unwanted children. Supportive partners or parents have been found to improve psychological outcomes for women (Bonevski & Adams, 2001). Also, Kroelinger and Oths (2000) found that a woman's partner has a substantial influence on women's experiences of unwanted pregnancy. The following factors impacted on this: partner's stability (financial status), feelings towards the pregnancy and level of dependability and support. These findings highlight that the support of a partner during pregnancy can have a positive influence on women wanting to continue with the pregnancy.

Reasons for termination and coping

Research investigating the reasons women give for having a termination has found that termination was often chosen when women were uncertain and perceived an adverse effect with continuing with the pregnancy (Kirkman, Rowe, Hardiman et al. 2009). These authors report that women considered their own needs, responsibility to existing children and the potential child, and the contribution of significant others, including the biological father.

The ways in which women cope psychologically with termination vary. Hess (2004) found that viewing the foetus as a person helps women deal with their grief following the termination. Interestingly, another study contradicts these findings as it found that consistent emotional upset was related to a more 'human view' of the foetus (Goodwin & Ogden, 2007). An additional study (Cozzarelli, Sumer & Major, 1998) found that women with high self-esteem were able to utilise their social support network and coped more effectively

following a termination. Women with low self-esteem were often left to cope alone after the procedure, as they were ineffective in seeking support from their partners.

In summary, some studies have found positive outcomes such as relief. Other studies suggest that support from a partner and parents improve the psychological outcome for women who have a termination. The decision to terminate a pregnancy due to medical or genetic reasons appears to have a greater negative impact and women report experiencing grief, anxiety and depression. Risk factors for negative psychological consequences can include pressure from a male partner, low self-esteem, poor social support, prior psychiatric illness and conflict with religious and cultural beliefs. For some women there can also be difficulty coping.

Limitations of existing research

Existing research examining psychological effects of termination are limited. Many studies do not include a comparison group therefore, it is difficult to assess whether the reported levels of distress in pregnant women is higher than the general population. In addition, some studies lack theoretical underpinning and use forms of measurement that are non-standardised, have small sample sizes possibly due to high drop-out rates, and have a relatively short follow-up period (Bradshaw & Slade, 2003). Furthermore, the method of termination, reasons for the termination, the ethnicity of women and the cut-off points used to indicate distress is often not specified. For long-term follow-up studies it is difficult to determine whether the reported levels of psychological distress are as a consequence of the termination or other distressing life events. In addition, research has not investigated the distress that can be caused by the government not sanctioning a termination and some studies do not report whether illegal and involuntary terminations are included in the sample.

There is a conceptual bias as past studies have generally focused on negative consequences although positive psychological outcomes are

evident. Furthermore, Lipp (2009) suggests that the results of studies on psychological consequences following termination do not consider the role of culture, religion, legal circumstances in which the termination takes place, the type of termination (medical or surgical) and the reason for the procedure. The author proposes that research in this area is dated as some studies were conducted when a termination was difficult to access; the process was more problematic and less socially acceptable than current methods. Therefore, procedures might have had greater psychological impact on women and affected psychological recovery.

There is literature suggesting that many women conceal their circumstances from family and friends because of the shame associated with terminations (Major & Gramzow, 1999), which perhaps has implications for psychological recovery. This issue has not been explored in any depth in the existing literature.

Given the findings and the short-comings of existing literature it is important to gain a greater understanding of issues, which may influence women's understandings, actions and reported distress.

South Asian populations

Studies conducted in Western populations have explored attitudes towards termination for specific conditions and across different conditions. Most studies, which have investigated attitudes towards termination in non-white populations, have generally been conducted outside of the UK (Ahmed et al. 2008). In the UK, research with South Asian communities has tended to focus on attitudes and perceptions to prenatal screening and termination due to abnormality of the foetus.

A study conducted in Pakistan (Arif et al. 2008) found that 23% of Pakistani adults were in favour for induced termination if the foetus had severe congenital abnormalities however, 15% were unwilling to consider a termination under any circumstances. Interestingly, women held more

favourable attitudes towards termination than men, and mutual agreement of husband and wife was important before making a decision regarding termination for 84% of participants.

A study conducted in the UK appears to contradict these findings. Ahmed et al. (2008) found that European and Pakistani women are similar in their attitudes towards termination. They found that, the most significant factor influencing women's decision about termination was women's perception of the quality of life of a child with a genetic condition. Another study compared White and Pakistani women's attitudes to termination of 30 different foetal conditions (Hewison et al. 2007). In comparison to White-British women, Asian-Pakistani women held less favourable attitudes to termination and women's views were dependent on the severity of the condition. Ahmed, Green and Hewison (2006b) investigated pregnant Pakistani women's attitudes towards termination for thalassaemia in England. The authors suggest that more women of Pakistani origin give birth to children with thalassaemia in the UK in comparison with other ethnic groups. An accepted explanation for this is that this group decline a termination, due to religious beliefs. However, this study found that Pakistani women's attitudes towards termination are not influenced by religious beliefs alone. Factors including attitudes towards the termination, perceptions of severity of the condition, influence of significant others and the impact of gestational age at the time of the offer of termination also influence women's decisions. The findings of these studies suggest there may be interplay between cultures and integration with the ethnic majority.

In summary, these findings indicate that studies conducted outside of the UK cannot be generalised to the UK population. White women appear to hold more favourable attitudes to termination than Asian women and both groups appear more accepting of a termination if there is foetal abnormality.

Generational shifts in attitude and behaviour

There exists a wealth of research on how particular ethnic, cultural or religious groups can hold different understandings of health and illness, and have different experiences of healthcare (Mir & Sheik, 2010). However, research in the area of ToP and ethnic groups in the UK is scarce. Although some shared experiences may exist between women who go through a ToP, the situation can be complex and ethnic identity may change overtime. For example, household patterns, attitudes to marriage and preferences when to bear children are all changeable.

It is likely that different social/cultural norms and religious beliefs operate in different countries and communities, which approve and disapprove of certain practices which influences people's attitudes and behaviour. The influence of the family and male partner, cultural and religious beliefs and level of support available are likely to be important factors when considering a termination, and reported levels of distress during and after a termination.

South Asian women's experiences are diverse, and there may be differences between women's attitudes and expectations and those of their parents (Hennink, Diamond & Cooper, 1999). There are also likely to be generational shifts in attitudes and beliefs as young people may share the social norms of the community in which they are integrating, while their parents and older members of the group may retain more traditional norms. In addition, rising career aspirations have also been identified among girls of Muslim faith (Bisit, 2002) and may be an important factor when considering a termination.

Islamic Perspectives

Religion is a powerful influence on attitudes and behaviour and often forms a societies orientation towards issues (Mir & Sheik, 2010). A religion can help to create a culture if it is practiced by many people and can influence others in the community. It is significant here to consider Islamic perspectives because the majority of participants included in this research identified themselves as

'Sunni-Muslim'. Also, when adhering to Discourse Analysis (DA) there are multiple perspectives and therefore, it is necessary to gain some knowledge of the various perspectives of Islam.

Research has a tendency of referring to Muslims as one homogeneous group. However, there are many personal interpretations of any religion and individual's beliefs can vary from liberal¹ to more traditional/ fundamental views². In addition, it is likely that factors such as ethnicity, age, sex, and social class can impact on people's religious beliefs.

There is no global perspective in Islam instead Islam represents a number of perspectives founded on various schools of thought. Muslims are primarily divided into two main groups, Sunni and Shias that are further divided into schools of thought (Syed, 2009). Ramadan (2004) suggests that the essential principles that form the basis of Islam are "with rare exceptions, unanimously recognised" (pg. 23). He proposes, "Islam is one and presents a body of opinion whose essential axes are identifiable and accepted by the various trends or schools of thought, in spite of their great diversity" (pg. 23). If Muslims accept that the Qur'an and the Sunnah as the scriptural points of reference for Islam (as these two main sources are not challenged by any schools of thought) then it is reasonable to explore the methods by which the various schools make reference to these texts (Ramadan, 2004). The Qur'an is the central religious text of Islam, which Muslims believe is the verbatim word of God and the final revelation to humanity. The Sunnah often lays down precise details of practice and is often traditions reported about the Prophet, it is the collection of what Muhammad said or did or approved in his lifetime (Lyad & Bewley, 1992).

Ramadan (2004) identified six different tendencies, which reflect the major trends of thought that are represented across the world by different groups (see appendix A). These trends may have different names but to a large extent have "adopted an identical, reading of the texts, along with the doctrinal

¹ This view maintains that Islam is compatible with social evolution if texts are interpreted properly.

² This view suggests that scope for interpretation of texts is limited.

and often social attitudes that follow as a consequence” (pg. 24). The trends are not exhaustive but do highlight some distinctions to counteract the dualistic simplistic readings of the situation that distinguish liberals from the radicals and the fundamentalists. However, the situation is complex and deep-rooted in history and the trends originate in particular ways of understanding the source texts.

Ramadan (2004) suggests that the scholastic traditionalists, the literalistic salafis and the politicised and radicalised salafis, despite their differences, agree that the texts, whether the Qur'an or the Sunnah can permit no interpretation or distortion. Reason is useful for understanding the text, but not, by extension, for deciding its purpose. The Qur'an text is the compulsory route to initiation for the Sufi traditions. For the reformist salafis, the text still remains the source, but reason, applied according to the rules of deduction and inference, permits significant scope for interpretation and elaboration. At the other end of doctrinally fixed positions, liberal reformism gives precedence to rational elaboration, while the scriptural texts have a major role in spiritual guidance and broad moral instruction, but always directed toward the individual, reflecting the way religious texts have come to be seen in the West in relation to the social and political life (Ramadan, 2004).

In the UK, the majority of Muslims follow Hanafi Deobandi (Sunni) school of thought (Nolfolk, 2007). It is reported that most mosques in the UK are run by Deobandi teachings (Norfolk, 2007) and the majority of mosque managers are of Pakistani and Bangladeshi origin (Bunglawala, 2007). It is likely that these teachings generally reflect the Scholastic Traditionalism tendency identified by Ramadan (2004).

An Islamic perspective on ToP

In Islam, a foetus in the womb is perceived as human life (Rizvi, 1994). This is expressed in the Qur'an (Al Muntanda al Islami, 2010) where people are informed that God views the killing of a human as a very serious matter. The

Qur'an states³: "whoever has spared the life of a soul; it is as though he has spared the life of all people. Whoever, has killed a soul it is as though he has murdered all of mankind" (Qur'an, 5:32). The Qur'an expresses that on the Day of Judgment parents who killed their children will face trial for these actions, and their children will act as witnesses against them (see Qur'an 81:8-9). The Qur'an also mentions that people often fear that having more children will compromise their financial stability. In response to this, the Qur'an says: "Do not slay your children for fear of poverty. We shall provide for them and for you" (Qur'an 17:31). In cases where one is already poor, the Qur'an states that God will provide sustenance for people and their children, and also teaches, "take not life which Allah has made sacred" (Qur'an 6:151). Although some people view these extracts as referring also, to a termination of a foetus, Syed (2009) argues that the Qur'an does not explicitly mention termination, which suggests there is scope for interpretation⁴.

The Shar'iah (Islamic law) allows a termination when doctors declare with reasonable certainty that continuing with the pregnancy will endanger the life of the mother (Rizvi, 1994). The mother is perceived as having duties and responsibilities and therefore, should be saved in these circumstances. Embryonic development is central to the Muslim perspectives on termination (Akbar, 1974). There is broad acceptance in the major Islamic schools of thought on the acceptability of terminations in the first 120 days of pregnancy (Syed, 2009). Despite the text Qur'an not permitting a ToP there are many perspectives (discourses) surrounding its permissibility, which are influenced by the Islamic tendencies and their relation to text and reason (Ramadan, 2004). Most of the schools that allow terminations argue that there must be a valid reason for a termination such as a threat to the mother's life or the probability of giving birth to a disabled child (Syed, 2009).

The background literature to this study has now been discussed. The researcher will now move on to consider why this research was necessary.

³ The researcher acknowledges that some readers may say that these views are taken out of context. However, for the purpose of readability the researcher presents these excerpts from the Qur'an.

⁴ This indicates that there may not be necessarily an exact view as this would be dependent on the wider context. For instance, a literal or liberal perspective.

Purpose of Investigation

Given the gaps identified in the literature, the proposed research aims to gain insight into how South Asian women think, understand and talk about ToP. Existing research is limited in aiding our understanding of ethnic variation in this area. Research into this area will develop our understanding of the factors that influence women's practices and the challenges South Asian women face if, considering a termination. This may in turn, influence the behavioural and psychological consequences prior to or following a termination. For example, women may experience negative psychological consequences if they practice a religion that prohibits termination, and/or live in a social context that disapproves of termination (Bonevski & Adams, 2001) or one in which women feel pressured into making a decision about whether to continue with, or terminate the pregnancy (Lipp, 2009; Broen et al. 2005a). This is significant because some women may benefit from psychological support following a termination. Therefore, eliciting factors that impact specifically on South Asian women will enable professionals to support women who are at risk of experiencing negative psychological consequences.

The researcher explored participants' ethnic identity and cultural and religious understandings in relation to termination. In all communities norms operate to prohibit certain attitudes and behaviours and to prescribe others (Nazroo, 1997). In addition, complex patterns of sexual lifestyle occur, where communities are in transition and where there is age-related diversity within the group (Coleman & Testa, 2008). It would be valuable to explore these views and the impact of such influences on South Asian women's understandings, health experiences and behaviours. This is an important area to explore, as generally, research (e.g. Bradshaw & Slade, 2003) has found that there are many factors that affect the rate of psychological recovery and reported levels of psychological distress prior to and following a termination but very little is known about this ethnic group in the UK. In addition, it has been suggested that the results of studies are confounded by religious and cultural factors and that results of studies may be dated (Lipp, 2009), as cultural norms change overtime.

Understanding the emotional impact of this process may provide an important contribution to public health and provide insight into the psychological needs of South Asian women. The findings may be useful in informing and developing psychological services for women in general, with an awareness of the needs of South Asian women. The needs of individuals are diverse and complex and some may require specialist assessment, counselling and care. Clinicians may need to remain sensitive to issues that have the potential to cause psychological distress in these women. Effective intervention can only be achieved through collaboration with communities, using culturally appropriate mechanisms.

Due to the impact of sociological factors (such as changing attitudes of women and their families) research in this area has the potential to become quickly dated therefore more up-to-date research is required. There is evidence to suggest that attitudes towards ToP have become significantly more liberal during 1990s amongst women in the UK (Scott, 1998) but we know little about the ethnicity of these women. Attitudes have the potential to influence stigmatism and secrecy, which influence disclosure and access to social support; known to be a protective factor against psychological distress in other areas (Dakof & Taylor, 1990).

The United Kingdom is a multicultural society and while significant strides have been made in terms of acceptance of its diversity, there are still unmet challenges. It is imperative to be aware of cultural and religious understandings of different ethnic groups as health and social care agencies face the challenge of providing a service that is equitable to all regardless of ethnic background, particularly, in light of the Race Relations Amendment Act (DOH, 2000) which enforces a duty on public authorities to be proactive towards meeting the needs of ethnic groups.

Women obtain a termination within different personal, social, and economic circumstances that influence the meaning of a termination and how others respond to women who have a termination. The experience of termination may vary as a function of a woman's ethnicity and culture, religious, spiritual,

and moral beliefs and those of others in their immediate social environment. Women's experiences of termination are also likely to be influenced by their personal appraisals of pregnancy and motherhood. Given these issues, it will be helpful to understand how ToP is constructed in relation to personal, social/cultural and religious systems as this is significant in supporting women at risk of experiencing negative psychological consequences.

Research exploring the intricate connections between faith, ethnicity and health, and which considers the implication of this relationship for those striving to develop culturally competent and sensitive care is necessary as this will reduce prejudice nurtured by stereotyped misconceptions and fostered by misrepresentations.

The aim of this research is to explore how discourses contribute to the construction of ToP. Specifically, how discourse operates through power/knowledge to produce 'truth' and the position South Asian women take in relation to this discourse.

Part Two: Extended Methodology

2. Section Introduction:

The purpose of this section is to detail the way in which the research was approached and conducted. In order to do this the researcher will revisit the aims of the research and highlight how this has influenced the methodology and the research methods selected.

Turpin, Barley, Beail et al. (1997) suggests that qualitative research allows exploration and understanding. It also provides the opportunity for participants to describe their own experiences and the meanings that a particular event has for them. With these ideas in mind, a qualitative approach was undertaken, as this enabled the researcher to understand the construct of ToP and in particular, how meanings are constructed and are shaped

discursively and through practice. Furthermore, this approach can also provide rich descriptions of complex and sensitive phenomenon and allows the exploration of culturally defined experiences (Willig, 2001).

Epistemology, Methodology and Methods

A framework for qualitative research was embraced for the purposes of this study and for analysing the data. The researcher was primarily interested in gaining an understanding of how South Asian women construct and make sense of ToP. Of particular interest were how discourses of ToP (created by powerful agencies), impact on the position women adopt in relation their views and experiences.

Epistemology: social constructionism

A post-modern, social constructionist framework is the underpinning of this research. The focus of social constructionism is on how “human experience, including perception, is mediated historically, culturally and linguistically” (Willig, 2001, [pg. 7]). Social constructionism proposes that what we perceive and experience is how we interpret environmental situations rather than a direct reflection of the environment (Willing, 2001). This approach proposes that there is no one single ‘knowledge’ rather there is multiple ‘knowledges’. One phenomenon can be described in many different ways but each is equally acceptable, as there are many ways of perceiving and understanding a phenomenon (Burr, 1995). Therefore, realities are created through subjective experiences that, over time and through practices, come to be viewed as ‘truths’ (Broaddus, 2002). These truths are usually internalised and act as a way of interpreting the world and therefore, how we make sense of ourselves and our experiences (White & Epsom, 1990).

Through adopting a social constructivist framework, the current research is interested in identifying the numerous ways South Asian women construct a social reality of ToP. The researcher is concerned with the meaning attributed to this concept and how participants interpret and make sense of this concept

and the implications of this on women's experiences and practices. This methodology will also enable the researcher to engage and reflect on the nature of the subjective experience and identify the discursive mechanisms at play which create particular ways of being and restate social connections (Parker, 2005). The researcher also attempts to acknowledge the impact of their own subjective reality that they bring to the research. Given these interests and the researcher's involvement, a methodology that permits and pursues variability and explores the way in which constructions are represented, was necessary.

Methodology: Discourse Analysis

Kaplan (1964) defines methodology as "the study- the description, the explanation, and the justification- of methods, by not the methods themselves" (p.18). The methodology selected to approach the data derived from this study was a discourse analytic theoretical framework. This approach was guided by the research objectives and the researcher's epistemological position. The methodology adopted guided the way the research was formulated, expressed, analysed and evaluated. It is important to note that because a social constructionist framework underpins this research, this informed the methodology adopted. This position can only address research questions about the social and/or discursive construction of phenomena and therefore was the most appropriate to use.

The methodology, which was applied to the interviews namely discourse analysis (DA) will now be discussed. This methodology has been summarised by Rapley (2007) as:

Rather than see it as a single, unitary, approach to the study of language-in-use, we could see it as a field of research, a collection of vaguely related practices and related theories for analyzing talk and texts, which emerge from a diverse range of sources (p. 4).

DA is an 'umbrella term' (Cameron, 2001) for many approaches and includes Discursive Psychology (DP), Critical DA (CDA) and Foucauldian DA (FDA). These approaches shift away from positivist ideas of viewing language as a route to obtain a single truth through accessing cognitions. Although all these approaches view participant's discourse as important, each has its own concepts and focuses on particular aspects in relation to the intended activity of the discourse (Potter & Wetherell, 1987). Each DA approach addresses different kinds of research questions (Willig, 2001). Given the aims of my research, FDA was most appropriate to use as this approach is interested in the discursive resources that are accessible to people, and how discourse constructs subjectivity, selfhood and power relations. DP, for example, was not useful because it is primarily concerned with how discursive resources are used by people to achieve interpersonal objectives in social interaction (Potter & Wetherell, 1987).

Theoretical framework: Foucault, power, knowledge and discourse

FDA is influenced by post-structural ideas, and in particular the contribution of Michael Foucault's work, who explored the relationship between language and subjectivity and the implications that this has for psychological research (Willig, 2001). According to Foucault (1972), to believe at face value what one hears, reads, or sees, as truth would lead to overlooking the social circumstances within which particular sets of ideas are produced, circulated and maintained. FDA is concerned with how people's thoughts, feelings and experiences are constructed. The approach proposes that the main way in which construction occurs is through the discursive exchanges that take place between people using the discourses that are available (Burr, 1995; Chadwick, 2001).

The concept of discourse is a significant component in Foucault's theoretical arguments and to his methodology (Rose, 2001). Foucault's (1972) meaning of 'discourse' varies from conventional linguistic definitions, which view discourse as passages of connected writing or speech. Foucault's definition of discourse centres on the production and circulation of knowledge/power.

According to Foucault (1981) particular knowledge systems convince individuals about what exists in the world. This knowledge about the world determines what individuals say and how things are conducted within it. The outcome of this is that there is space for variance in identity formation, and room to manipulate power (Foucault, 1981). Foucault (1981; 1984a; 1984b) proposes that discourse operate in four main ways:

i) Discourse influences how we perceive the world through drawing on the associations we make. This creates a meaningful understanding and organises the way we respond to other people and objects in the world. Hence, discourses play a key role in how social reality is constructed (Burr, 1995).

ii) Discourse not only constructs our world but also generates knowledge and 'truth'. Foucault proposes that knowledge is not only communicated in language but also through structures, interconnections and associations, which are embedded into language. In some social contexts discourses have the power to persuade people to accept things as true.

iii) Discourse conveys knowledge about the person uttering the discourse. The discourse a speaker uses can be analysed and this can reveal information about the speaker such as their gender, ethnicity, sexuality and social status. It can also reveal information about the speaker's suggested relationship with others around them. Burr (1995) suggests that Foucault was interested in exploring discourse that not everyone was permitted to use, or that involve specific locations to gain authority.

iv) Discourse operates, through being closely involved with socially embedded networks of power. The amount of power an individual has is related to their ability to contribute to numerous dominant discourses that influence society. Discourses that are preferred and legitimised produce meaning and preserve ideologies. The exclusion of discourses allows silencing and marginalising of others, which maintains the existing power structures.

Foucault has identified several discursive mechanisms that operate to organise, reinforce/strengthen or subjugate discourse. Foucault (1981) refers to division and rejection/ “the will of truth” (pg.61). This is concerned with the separation of discourses according to assumptions about their significance. Therefore, alternative sources of knowledge can be dismissed if they are seen as ‘false’. Foucault (1981) also refers to commentary and authorship where key texts or narratives control, inform and limit discourse through only permitting people access to a ‘true’ commentary of an issue.

People also subjugate themselves through being repeatedly evaluated and judged in relation to the social norms (Burr, 1995). Subjugation refers to ways of thinking and doing that have been concealed, devalued, or made invisible through the dominant operation of power/knowledge (Foucault 1991a). Through involvement in the social environment people come to perceive dominant discourses as normative standards, which work vigorously to create conformity (McNay, 1994). The pressure to conform demolishes independence, restricting people to the prescribed patterns, which become linked to their identity (Gordon 1990). These practices operate to make individuals sightless to the possibilities of other positions and continue to subjugate people to normative standards (Freedman & Combs, 1996). The development of a deviant identity can occur through people internalising perceived disapproval and rejection by society (Ulrich & Wetherell, 2000). The subject positions people adopt set limits for negotiating their lives and create the foundation for defining the self.

Foucault (1980) proposes that questions about the ‘truth’ of knowledge are useless because truth is unattainable. According to Foucault, the mutual relationship between power and knowledge is underpinned by discursive structures. While Foucault understands discourses to be inherently unstable, discursive structures are understood to ‘fix’ ideas of the world within particular social groups at specific historical and spatial junctures. Discursive structures are a subtle form of social power that fix, give apparent unity to, constrain, and/or naturalise as common sense particular ideas, attitudes and practices. Foucault refers to this form of social control as “the effects of truth” (pg. 87)

This study considers the use of discourse in power relationships. It explores the discursive mechanisms that operate to legitimise dominant discourses and explores how alternative discourses are marginalised and silenced. The research also explores how individuals are made sightless to the possibilities of alternative positions and subjugated to normative standards.

Discourse analysis is a difficult-to-define method (Berg, 2009) and interestingly, in Foucault's writings he has not outlined a template of how to conduct discourse analysis (Rose, 2007). This was because Foucault feared that "a methodological template would become too formulaic and reductionist" (Waitt, 2005; p.219). It is likely that the absence of a methodological template has led people to describe Foucault's methodological statements as "vague" (Barret, 1991 [pg.127]). There is also an absence of formal guidelines in qualitative research handbooks (Potter, 1996). Furthermore, it has been suggested that guidelines undermine the potential for discourse analysis (Waitt, 2005). For example, Potter (1996) suggests that guidelines work in opposition to discourse analysis as a "craft skill" (pg. 140) and limit the researcher's ability "to customise" (Philips & Hardy, 2002 [pg. 78]) or inhibit demands for "rigorous scholarship" (Gill, 1996 [p.144]) and "human intellect" (Duncan, 1987 [pg. 473]). Burman and Parker (1993) proposed that you only learn discourse analysis through doing it and any methodological template would be viewed as too systematic, mechanical and formulaic.

Model of analysis

Given that FDA is concerned with how discourses facilitate and restrict, allow and constrain what can be said, by whom, where and when (Parker, 1992) a model (Berg, 2009) which allowed exploration of discourse and its relationship with how people think or feel, their practices and the situations within which such experiences take place was adopted.

The data from the interviews was analysed using Berg's (2009) method for doing discourse analysis (see table 3). This model is based on Rose's (2001) seven key methodological components to discourse analysis of visual

materials (referred to here as textual materials). These stages will now be discussed and later applied when analysing textual data from the interviews.

Table 3: Key methodological components for doing discourse analysis of textual materials (Berg, 2009).

	Stages of analysis
1.	Suspending pre-existing categories
2.	Absorbing oneself in the texts
3.	Coding themes
4.	Identifying 'regimes of truth'
5.	Identifying inconsistencies
6.	Identifying absent presences
7.	Identifying social contexts

Suspending pre-existing categories

Foucault (1972) proposed that the starting point for discourse analysis is reading, listening, or looking at the data with 'fresh' eyes and ears. He argued that preconceptions needed to be put aside because the objective of discourse analysis is to create 'naturalness' of the created categories, subjectivities, particularities, accountability and responsibility.

Foucault (1972) acknowledges that this request to defer pre-existing categories is an impossible task. It is unattainable because, according to Foucault, all knowledge is socially created. There is no independent position from which to suspend pre-existing knowledge. Instead, Foucault stated that researchers needed to become self-critically aware of the ideas that inform their understandings of a particular topic.

Absorbing oneself in the texts

Berg (2009) suggests that it is significant for the researcher to "absorb themselves in their object of analysis" (pg.219). This entails becoming entirely acquainted with the texts and engaging in the process of reading and re-

reading, to identify any particular themes that are evident in the reading of the texts.

Coding Themes

When doing discourse analysis, coding can be done in many ways and typically involves some way of categorisation of certain features of the objects of analysis (Berg, 2009). Coding serves two main functions: organisation and analysis of texts (Waitt, 2005).

During this process it is important to note “the ways that the producer and consumer of the text are positioned by the text” (Berg, 2009; pg. 219). In addition, there is a need to understand how objects such as people and places are positioned textually. Interestingly, Berg (2009) suggested that researchers should aim to address the following questions:

does the producer use third person narrative, distancing themselves from the text? How is the author of a text explicitly or implicitly gendered? Is the text written from a ‘masculine’ or ‘feminine’ perspective? Is the reader assumed to occupy a particular social class? Are people in the text racialised? Are there particular stereotypes drawn upon or reinforced in the text? What role does space play in the constitution of subjectivities and subject positions? (pg. 219).

Identifying ‘regimes of truth’

All discourses rely upon specific knowledge that specifies the validity of ideas, practices and attitudes in terms of truth/falsehood, normal/abnormal, moral/immoral etc. (Berg, 2009). Therefore, it is helpful to attempt to understand the mechanisms by which a particular discourse is seen to have both validity and worth. Berg (2009) stated that it is important to ask “what patterns of ‘truth’ can be recognised? What experts are called upon to pronounce truth?” (pg.219).

Identifying Inconsistencies

Hegemonic discourses are continuously questioned by subordinate discourses and “all discourses are characterised by inconsistencies, contradictions and paradoxes” (Berg, 2009; pg.219). Hence, it is theoretically significant to recognise these inconsistencies and to explore how these inconsistencies might challenge or support the dominant meanings created in a given discourse. Of particular importance is that these inconsistencies and challenges allow for the construction of new subject positions and identities in discourse (Berg, 2009).

Identifying Absent Presences

Rose (2001) proposes that “silences are as productive as explicit naming; invisibility can have just as powerful effects as visibility” (pg. 157). In addition, Berg (2009) stated that because discourses are often reliant on their silences for their power it is significant to “identify these silences and to theorise how they operate to create particular subjects and how they might erase others” (pg. 219).

Identifying Social Contexts

It is crucial to recognise the social context within which discourses arise, or which may be constituted in and by discourses. Berg proposes that the main task here is:

to attempt to link the production of discourse with the production of key subject positions (audience, reader, writer, producer etc.) and to think about how power operates in these contexts to (re)produce social relations and subject positions for social actors (pg.220).

Methods

Ethics- Approval for the research

An application for ethical consideration for this research was made to the Research and Development department at the University of Lincoln. Initially,

ethics was requested and granted for recruitment from the Nottinghamshire area. However, due to difficulties in the recruitment of South Asian women, ethical approval was requested again six months later, this time to also recruit South Asian women from the South Yorkshire area. The data was collected following ethical approval from the University Ethics Board (see appendix B).

Sample size

The sample size was decided following consideration of the scope of the study, the sensitive area being explored and the quality of the data. The study design and the feasibility of the research within the proposed time-scale were also considered.

Participants

Six South Asian women participated in this research. The sample included one woman who was born in Pakistan and five women born in the UK. These South Asian women comprised of different ages (24-40 years). Five of these women identified themselves as Pakistani Sunni-Muslim and one as Indian-Hindu. Four of these women were in full-time employment. Of these women, none had children and one of these four women was married. The remaining two women were both married and mothers of young children. They were both unemployed and one of these women was born in Pakistan, then married and moved to the UK seven years ago to be with her husband.

Inclusion Criteria

All participants who took part in the study met the following inclusion criteria: women who self-assigned their ethnicity as South Asian namely, Bangladeshi, Indian and Pakistani; were above eighteen years of age, (because an adult population was required and also to ensure informed consent to take part in the study) and those who were conversant in English. The use of interpreters was considered but this was not appropriate because of the sensitive topic area being explored and also the potential for information to be lost and

misinterpreted in the process of translation (Willig, 2001).

Recruitment and Procedure

Purposive sampling by ethnic background was used to recruit participants from two community centres in Nottingham and one community centre in Sheffield. Women from ethnic minority backgrounds usually access these community centres. The centres offer information, advocacy, a mentoring service, educational opportunities and training. Women can also access social and recreational activities at the centre.

Initially, a letter (see appendix C) was sent out to the manager of each centre to obtain permission to recruit South Asian women who accessed services at the centre. Following permission from managers, participant information packs was sent to each centre and was distributed to women by staff at each centre (see appendix D). This information provided details about the nature of the study and informed women that the researcher would make contact again shortly to see if anyone is interested in taking part. Women were also informed that if they required any further information then they could get in touch using the contact details provided. Also, that the researcher was happy to come and speak with them and answer any additional questions. Enclosed with this pack were posters (see appendix E) detailing information about the study and it was requested that the posters are displayed at the community centres.

A meeting was arranged prior to the interview with women who contacted the researcher and expressed an interest in becoming involved in the study. The aim of this was to discuss the research and to allow the opportunity for questions. A demographic data sheet (appendix F) was given to participants for completion during this meeting, which was used to describe the sample and ensure that women met the inclusion criteria. A consent form (appendix G) was also given to each participant during this meeting for completion. Written permission to audio-record the interview was obtained. Participants were made aware that if they wished to withdraw their consent then this could

be done up until the write-up of the research by notifying the researcher. Participants were asked to specify on the consent form if they would like to be provided with a summary of the findings of the research once this had been completed.

The researcher conducted all of the interviews in English, in local community centres. Whilst conducting the research, the Nottinghamshire NHS lone working policy was adhered to. Following the interview participants questions and/or concerns were addressed. All participants were provided with a free counselling helpline number for Care Confidential. This is a service providing pregnancy and post termination support. Participants were also advised to contact their GP if they have been affected by any of the issues raised and require any additional support.

Interview Schedule and Piloting

The interview protocol was carefully constructed to ensure that the interviewer covered all issues of interest. Semi-structured interviews were carried out that included open-ended questions surrounding three key areas: views and opinions of ToP, societal/cultural and/or religious views and the role of significant others. The interview began with general questions to establish rapport before asking specific questions, which were considered to be more personal to individuals.

The interview schedule used in the study was given to lay persons to check their understanding to ensure that the language used and the ideas conveyed were clear and coherent. Modifications to the interview schedule specifically, language-usage was made following this consultation (appendix H).

Demographic information sheet

The demographic sheet asked participants their age, relationship status, whether they had any children, their ethnicity, religious views (if any), their occupation, where they were born, where their parents were born and also

which country their grandparents originated from. Women were also asked to specify if English was their first language and if not which language was their first language. This information was simply used to describe the sample and to ensure that participants met the inclusion criteria.

Gaining Informed Consent

When recruiting participants for the interview the role of the researcher was explained. Participants were informed about how the data from the interviews would be used. In particular, participants were made aware that direct quotes from the interviews would be used when writing the thesis. The arrangements that were put in place to ensure that women are not personally identifiable were explained to participants. Written consent was obtained, and women were given the opportunity to ask questions and discuss the study prior to making a decision on whether to take part.

Preserving Confidentiality and Anonymity

The researcher compiled a list containing women's names, contact details and the date of the interview and this was kept in a locked cabinet. Following each audio-recorded interview a pseudonym was assigned to each woman and this appeared on all the data produced during the research process. The list linking women with their pseudonyms and the data was kept in locked, separate cabinets with different keys.

Recording and transcription equipment

Each of the interviews was recorded on an Olympus DS-30 digital voice recorder and recordings were transcribed soon after each interview. An Olympus AS-2300 transcription kit was used to transcribe the audio data obtained from the interviews.

Transcription

Researchers interested in the study of language and those exploring dimensions of everyday life generally use transcribing as a tool to achieve this (Green, Franquix & Dixon, 1997). However, Ochs (1979) stated the 'transcription procedure is responsive to cultural biases and itself biases readings and inferences' (pg. 44). During the process of transcription the researcher became aware that transcription could not be separated from theory, analysis and interpretation because the data could be transcribed and interpreted in various ways depending on theoretical stance of the researcher. Interestingly, Edwards (1993) suggests transcribing is a political act that is embedded in a discipline and reflects a researcher's perspective of a phenomenon, goals and purposes for the research and theoretical framework guiding the data collection and analysis.

The research data was obtained from six individual interviews. The audio data produced from the interviews was transcribed using an adapted version of the Jeffersonian transcription notation system (Rapley, 2007 [appendix I]).

Quality Issues

Reicher (2000) suggests that quantitative concepts such as reliability and validity cannot be applied to qualitative research. Furthermore, the researcher's epistemological position rejects the idea of one single truth or reality and instead argues that there are multiple truths and each of these is valid. Together with many others, the researcher holds a social constructionist and relativist position and therefore, was not searching for reliability and validity but instead sought to establish credibility and quality assurance of the data produced. Despite quantitative concepts being unsuited to this study, it has been suggested that it is crucial to evaluate the quality of research (Denzin & Lincoln, 1998) however, Taylor (2001) argued that no single approach has yet been agreed to achieve this. Perhaps this is due to the many epistemologies and methodologies present in qualitative research.

Credibility, Quality Assurance and Trustworthiness

To ensure quality assurance all the data produced from the transcription of the interviews was checked against the audio-file for accuracy and consistency. To ensure that the research is credible and to maintain quality assurance an audit trail consisting of detailed and accurate descriptions of the research steps taken throughout the project was kept. It was hoped that through the researcher's use of an audit trail that this would increase trustworthiness of the analysis and demonstrate transparency.

Reflexivity

Throughout the research process the researcher was aware of their own contribution to the construction of meanings. The researcher soon realised that it was not possible to remain outside of the area being investigated. Therefore, they considered the ways in which their involvement influenced the research.

This was achieved in two ways: first, personal reflexivity enabled the researcher to reflect on the ways their own personal experiences, their interests, values and beliefs and also how their identity may have contributed to the constructions of meaning throughout the research process. Here, the researcher also considered the impact of the study on the researcher and as an individual. Reflexive strategies were integrated into the research process, with the aim of acknowledging the researcher's beliefs, values and position on the issues being investigated. This was primarily informed by their own thoughts and actions. The reflexive strategies for implementation included the completion of self-reflective records and a diary, which examined personal assumptions and goals during the entire research process. Second, epistemological reflexivity enabled the researcher to reflect on the assumptions that they made about the world and about knowledge throughout the research process and the implications of these assumptions for the research and its findings.

Interestingly, Fairclough (1995) proposes that 'critical language awareness' is also part of reflexivity. People use language to explain their experiences and

this plays a role in the construction of the meanings people ascribe to such experiences. Findings are also influenced by the categories and labels used by the researcher during the research process (Fairclough, 1995) For example, by asking certain questions participants will position themselves in relation to this construct even if it is not of importance to them. The researcher has been mindful of these issues whilst conducting this research.

Document Analysis

As mentioned in greater detail in the journal paper, two publications about ToP (Royal College of Obstetricians and Gynaecologists [RCOG], 2010) and 'Abortion: your questions answered,' (Family Planning Association [FPA], 2010) were examined to characterise the healthcare and legislative discourse around ToP. These publications were subject to Braun and Clarke's (2006) model of thematic analysis to draw out key themes evident. These themes are discussed in the journal paper.

In order to identify what information is produced and available for women to access, six GP surgeries situated within close proximity of the community centres identified for recruitment were approached. It was found that of the six surgeries contacted two had the FPA publication and one surgery had the RCOG publication available for women to access. However, three surgeries had no published information available and none of the surgeries contacted had this information available in any other languages but English. These observations suggest that there are gaps in service provision of such information, in particular lack of information available and also a lack of appropriate language support that may disadvantage women from non-English speaking backgrounds. It is important to note that the document analysis was merely a preparatory stage and was not the key aim of the study.

Part Three: Extended Analysis and Discussion

3. Section Introduction

This section is selective in what is presented due to the large amount of data accumulated from the interviews. Throughout the analysis the researcher attempted to reflect on how she was positioned during the research. This is important because it is recognised that writing and reporting in qualitative research are an integral part of the analytic process and a researcher's thinking and interpretation commonly develops through the process of writing (Richardson, 2000).

The textual data was analysed using Berg's (2009) model of analysis. In keeping with the structure of this model the researcher evidences the process and begins by discussing how she suspended preexisting categories, absorbed herself with the data and coded themes from the data. The data is then analysed and discussed in relation to Foucault's theoretical ideas.

Step one- Suspending pre-existing categories

Prior to engaging with the data the researcher attempted to step outside hegemonic discourses, in order to examine her own position in the discourse and understand how her position helps to create certain understandings of the issues under analysis. During this process of reflexive analysis the researcher thought about how she felt toward ToP, where she was positioned during the interview and how participants viewed her in terms of her gender, ethnicity and religious identity markers (e.g., her name). The researcher will first consider why she chose to investigate this topic and her own position in relation to this area.

The interest in ToP arose from when the researcher was employed in a resource centre accessed by ethnic minorities. The researcher became aware of religious and cultural discourses that were prevalent and had the potential to influence women's understandings. Women reported that there were both cultural and religious expectations that they felt pressured to fulfill. Also, the

family appeared to be important to women and had a significant involvement in their lives. The researcher noticed that generally women, who sought advice, had limited knowledge about healthcare services available and tended to rely on others for information.

The researcher considered how her identity might have impacted on how participants interacted during the interview, and the experiences women shared. Women were forthcoming in discussing the topic but it is possible that the manner in which responses were constructed and/or the amount of detail given, was influenced by participant's perception of the researcher. All the women who were interviewed identified like the researcher, as South Asian. In addition, most women reported that their faith is Islam, the faith the researcher also subscribes to. Given these commonalities it was necessary for the researcher to consider how her personal characteristics (being female, Muslim, South Asian and not being a mother) may have influenced participant's perception of her and what implications this had for the interviews. ToP is a sensitive area and it is likely that women will hold strong and widely differing views. The researcher felt given that she shared similar characteristics as participants, women would be honest and forthcoming during the interviews. This commonality did facilitate conversation as women appeared at ease with sharing their views. Although the researcher did not share her religious beliefs or her ethnic identity this may have been apparent to participants. Hence, it is likely participants held assumptions about the researcher. During the interviews some participants seemed to assume that the researcher had knowledge of Islamic perspectives or knew what "life was like" living within a close-knit community.

It can be argued that because some participants assumed that the researcher was 'Muslim' and 'South Asian' they responded in a more desirable way where perhaps, they presented as conforming to religious and cultural practices. However, it is important to mention that simply because participants may have perceived the researcher as 'Muslim' and 'South Asian' does not mean that they shared the same religious perspective and cultural ideas. As illustrated earlier there are various Islamic tendencies, for which Islam is the

reference point for thinking and engagement (Ramadan, 2004).

The researcher felt that because she had some understanding of religious and cultural perspectives, this enabled her to ask appropriate questions in a sensitive and exploratory manner. The researcher has to acknowledge that her age, employment status and participants assuming that she does not have children may also, have had an effect on how some women considered themselves in relation to the researcher and how they framed their responses. During the interviews the researcher felt, from her own experiences that religion, culture and family would be important to women. Also, severity of the condition and stage of gestation may also be important in how women viewed termination. The researcher attempted to refrain from asking questions related to her own preexisting assumptions to avoid imposing these categories on participants.

After engaging in this critically reflective process through specifying why the researcher had an interest in the topic and also reporting her own life experiences in order to try and locate herself within research, the researcher moved onto familiarising herself with the data obtained from the interviews.

Step two- Absorbing oneself in the texts

Transcribing the tapes provided the researcher with an opportunity to become entirely immersed in the content. The researcher was able to reflect on her style of questioning. Particular attention was given to asking questions broadly, in order for participants to speak about what was important to them. For example, only when participants spoke about their religious beliefs were participants then prompted by the researcher about how ToP was viewed in their religion.

Once the researcher had a complete set of written transcripts available, she absorbed herself in the objects of analysis. This involved becoming familiar with the transcripts, studying them and beginning through the process of 'reading' and 're-reading' to identify themes arising in the reading of the texts.

During this process the data was analysed at a surface level to broadly think about what material had been shared during the interviews. Interestingly, the researcher noticed immediately that most Muslim participants drew heavily upon scriptural texts when sharing their views. Both religious and cultural beliefs were important in influencing how women viewed termination and informed their practices. Furthermore, ToP was seen as a taboo topic for all participants. Participants stated that termination is not openly spoken about in their community because it was not seen as acceptable practice. Hence, there would be negative consequences for women who did have a termination. Participants also suggested that women considering a termination would be fearful of the reactions of others and would feel isolated because they would not be able to confide in others or seek their support. Also, participants expressed that women undergoing a termination were likely to experience shame, guilt and regret. There also appeared to be a rejection of medical discourse in favour of a religious discourse where the views of health professionals was perceived as irrelevant to Pakistani Sunni-Muslim women.

Step three- Coding themes

For the researcher, the main purpose for coding was: to reduce data; to create an organisational structure; and, aid analysis. Coding also provided the opportunity for continued critical self-evaluation of the research process. By continually reviewing the data and connections between the codes, the researcher was able to see elements of her own research practice, participant's representations, and broader strategies of knowledge construction that had not previously been apparent.

Once the researcher was familiar with the objects of analysis, she coded the data for particular themes that arose in the reading of the transcripts. Drawing on Foucault's ideas attention was given to the context, practices, perspectives and experiences of participants when developing a list of descriptive codes and this helped in organising the data. To begin with the researcher wrote each theme on paper, and then listed the pertinent points made by each participant. The researcher also recorded key quotes which could be used in written material as suggested by Bertrand, Brown and Ward, (1992).

The themes, which were identified and coded included: devaluation of the medical profession, ideas of marriage and motherhood, family pressures and involvement in decisions, experiences of fear, shame and guilt, community/culture and the influence of religion.

During this process of coding themes, the researcher identified the various and sometimes contradictory ways termination was spoken about and how these represented ToP. For Foucault (1972) discourses are productive as they have power outcomes and they define and establish truth. Hence, at particular moments, they construct a particular version of termination as real. Consequently, in the case of this research, the researcher was interested in how discourse operate to produce a particular 'truth' of ToP, which seeks to invalidate other accounts.

The researcher considered constitutions of subjectivities. All participants spoke from a feminine perspective and participants reported a religious and ethnic identity. In addition, participants spoke in reference to cultural norms and expectations. Interestingly, the researcher noticed that on occasions, women distanced themselves from the issue of ToP. This was done through stating that they had never considered the area because termination would not be an option for them, because they were Muslim, and that this practice went against their religious beliefs. There were also instances where participants drew upon third person narratives and certain ethnic groups were racialised and stereotyped.

The researcher reflected on how participants represented themselves, and the subject positions they took up (see step 7). Many women constructed decisions to terminate a pregnancy as immoral and wrong. Women emphasised that children are significant, a blessing from God and 'natural' as part of marriage in Islam. Given these ideas it would be difficult for a Muslim woman to resist these maternal ideas when they are closely linked with a woman's identity in their view of Islam. Also, women reported that within their culture being a mother is an important role for South Asian women to fulfil. Hence, if women are seen to resist this subject position they might be

perceived as challenging religious and cultural practices (Burr, 1995). Self-subjugation was evidenced in how women reported that in their experience women who terminated a pregnancy struggled with guilt and shame but was not be openly spoken about during the interviews perhaps because terminations are perceived as taboo and wrongful practice.

Where relevant and possible, some of the themes identified are explored in greater depth during the analysis.

Step four- Regimes of truth

During this stage of the analysis the data was explored for 'effects of truth'. Drawing on Foucault's (1972; 1981) ideas, the researcher considered how relatively powerful networks are able to naturalise meanings, attitudes, and practices towards another social group constituted as 'unworthy'. First, the researcher remained alert to institutional dynamics. Second, while discourses are always inherently unstable, multiple, and contradictory, discursive structures operate to give fixity, bringing a common sense order to the world. Particular sets of ideas become accepted and repeated by most people as 'common-sense', unproblematic, unquestionable, and apparently 'natural'. Hence, when doing this stage of the analysis it was essential that the researcher was aware of the ways in which particular kinds of knowledge become understood as valid, legitimate, trustworthy, or authoritative. This knowledge encompassed the way that sets of ideas are legitimised by the subtle deployment of different knowledge-making practices or categories of spoken people.

In brief, participants called upon discourses underlying religious and cultural ideas to pronounce 'truth'. Participants believed that these voices were sources of 'factual' knowledge and they shared these perspectives during the interviews. Interestingly, these ideas had precedence and were valued far greater than a medical discourse. The knowledge and views of medical professionals were rejected, as they were not seen as relevant to Muslim women.

During this stage of analysis, religious and cultural ideas are discussed and specific discourses, which gave precedence to these overarching ideas, are explored in greater detail.

Religion

Religion was viewed as a reliable source for obtaining 'truth' and 'knowledge'. Most women who were interviewed drew upon religious ideas and reported that their knowledge, including their perspective of ToP came from their religion, Islam. The majority of women spoke about Islam being important to them and felt that their religion provided them with 'factual' and 'truthful' knowledge. This helped to create meaning and informed women's practices. When women discussed the circumstances in which termination would be accepted in Islam they spoke in reference to scriptural texts such as the Qur'an, and they too shared these views.

Extracts from the interviews will now be discussed in conjunction with the mechanisms by which certain discourses (underlying religious and cultural ideas) are seen to have validity and worth. Foucault's theoretical ideas are applied here, to explore 'the effects of truth'.

Prohibition

Evident in the data was a discourse about ToP being a prohibited act in Islam and suggestions of the circumstances under which ToP would be acceptable. All Muslim women interviewed stated that termination was prohibited in Islam and therefore, they would not consider a termination under any circumstances. The exception to this would be if a woman's life were endangered by the pregnancy. Rizwana shares her thoughts on what she believes Islam says about terminations:

Extract 1:

"from what I know it's WRONG that's what our Islam says it's wrong to have an abortion like I said if it's a matter of life and death go ahead with it (.) but if

it's NOT matter of life and death I don't think it's ALLOWED (.) I don't think it's allowed in our religion in our Islam..." (lines: 294-298).

Rizwana views ToP as a prohibited act and indicates that Islam has clear and fixed ideas about this issue. By suggesting that termination is "*WRONG*" because it goes against what religion prescribes, it serves to command women to refrain from terminations. Therefore, the outcome could be the casting of women who seek and/or obtain termination as disobedient and sinful, not respecting what God articulates and the value of human life. Rizwana uses the word "*our*" several times, emphasising that she too belongs to and affiliates with this religion. There is a sense of group cohesiveness as Rizwana suggests that this view is shared and supported by many others, also perhaps reading that the interviewer is a fellow Muslim, thereby co-opting her in subscribing to this view.

Extract 1 illustrates the Foucauldian notion of 'division and rejection' (Foucault, 1972) where there is a separation of discourses based upon assumptions of their relative importance and alternative bodies of knowledge are dismissed. This extract illustrates that only what Islam says about termination is worthy of knowing, as this discipline is the source of 'truth'. Rizwana views suggest that to belong to Islam you must have a particular frame of knowledge ("*I know it's WRONG that's what our Islam says*"). Hence, Islam acts as a system of control for the production of discourse and this acts to maintain the religious boundaries.

Foucault (1981) suggests that social groups benefit from discursive power and through discourse power and knowledge operate here to convince women to construct the act of termination as prohibited. Rizwana progresses from referring to religion generally to more specifically ("*our religion in our Islam*"). This suggests that she is keen to identify with a particular religion and this religion is constructed as worthy and the most truthful.

Rizwana also shares her own views on termination, which are based on her religious understandings of termination being prohibited:

Extract 2:

"I think the women that do have abortions (.) I think that firstly they should THINK what they are about to do its like KILLING A CHILD...like killing a child you're killing your OWN child and I think it's really really wrong..." (lines: 67-70).

Rizwana suggests that women's actions are more than simply terminating a foetus. Rizwana appears to be aware that some women may not view the foetus as a human life and therefore, may feel that a termination is justified. By constructing the termination as a "*killing*" and the object of this crime a "*CHILD*" and "*your OWN child*", she constructs ToP as an immoral act. Rizwana personalises the child as something belonging to the mother and there is suggestion that it is a mother's duty to take care of her child and not cause them harm. Rizwana appears to sit in judgement here (*'it's really really wrong'*) and the emphasis is on urging women to think about their action. There is suggestion that women have not thought through their decisions (with her repeated use of the word "*think*"), which constitutes termination as unacceptable practice.

When Rizwana uses the phrase "*what our Islam says...*" (Extract 1) she is perhaps using personification as a rhetorical figure by invoking scripture. Through Muslims viewing the Qur'an as the edicts of God, this implies that it is understood as legitimate, authoritative and unquestionable. This extract supports Foucault's ideas of 'commentary and authorship' and illustrates how religious texts come to limit, control and inform discourse, through only allowing them access to a 'true' commentary of an issue, and in this case ToP. This discourse has productive mechanisms and may produce certain behaviours such as the repetition of normative ideas and 'common-sense' notions that are accepted as true. This has the effect of influencing others' perspectives and practices. For Foucault (1972), discourses that are preferred and legitimised operate to communicate meaning and preserve dominant ideologies.

Extracts 1 and 2 illustrate how forceful Rizwana is within her views. Perhaps this is because she feels supported by others who share similar views. This discourse of a termination being prohibited has productive mechanisms and can have an effect on how people think, feel and how they view termination. The power of this discourse not only prevents women, such as Rizwana, from viewing a termination as unacceptable practice and prohibited, but also produces certain behaviours such as repeating accepted ideas which has the effect of influencing others perspectives and practices. Ideas such as these, illustrate how discourse is productive and the ways in which discourse 'hook' into normative ideas and common-sense notions. For instance, by locating ToP with ideas relating to religion the concept is constructed as bad, immoral and wrong.

Rizwana does not articulate the social circumstances within which ideas about termination is produced, circulated and maintained (see extract 1 & 2). According to Foucault (1972) through excluding alternative discourses the views of others are silenced and marginalised and this acts to maintain the existing power structures.

There was one woman in the study, Meena, who identified as Indian but chose not to practice her religion, Hinduism. In contrast to Muslim participants, Meena did not identify with a religious discourse. There was limited internal struggle with religion evident in Meena's views on termination:

Extract 3:

"...in any religion or just erm (.) and just as a person ((laughs)) you're not suppose to kill people (.) and technically you are killing a baby... I guess if I was religious then I'd think that's completely wrong erm (.) but I'm not and I understand that (.) life isn't always black and white" (lines: 229-233).

Meena recognises that in all religions (and also morally), terminations are viewed as wrong because "you're not suppose to kill people." Meena laughs whilst saying this perhaps suggesting that the idea is absurd, and her use of

the term “*technically*” suggests detail and exactness illustrating that this perspective is a focused and restricted view. Meena suggests that those who are “*religious*” view terminations as “*completely wrong*.” However, Meena appears to reject the idea of viewing terminations as “*killing a baby*” through implying that religion is “*black and white*” and that life cannot always be seen in this way. Meena’s views suggest that the maintenance of religious boundaries appears to restrict the degree to which social change is possible.

According to Foucault (1972) a network of interactions among several sectors aside from religion, act to shape Meena’s knowledge. For Foucault, knowledge is created as a product of complex interactions among struggling and competing sectors. Foucault (1972) posits that individuals who are able to participate in the numerous discourses that influence society is proportionate to the amount of power that individual holds.

Circumstances of acceptance

Women were asked if there were any circumstances where termination may be acceptable following discussion of their religious views (other than if the life of the mother was endangered). Some women referred to a “grey area” where, it may be permissible to obtain a ToP. Tasleem reported:

Extract 4:

“... there’s sort of a grey area is if the child was you know at a risk of having disabilities or you know mental or physical problems later on (.)... then the other thing I suppose is (.) rape and things like that...” (lines: 280-283).

There appears to be some space for consideration of personal circumstances when making this decision. Extract 4 suggests a ‘loophole’ that perhaps produces ambiguity in the certainty of terminating a pregnancy in these circumstances in Islam. Tasleem appears uncertain of the exact circumstances under which a termination may be permissible. However, it is also possible that this area is seen as taboo and is therefore not openly

spoken about. Her use of language such as “*you know*” and “*things like that*” may represent an attempt to avoid giving any detail or thought. In addition, although Tasleem refers to a “*grey area*” all the women in the study reported that they personally would not consider a termination for these reasons.

It is important to consider where women’s knowledge and understanding is derived from, for example in most Muslim cultures it is men who are Imams and the ones that interpret the Qur’an for the community. The Qur’an states, “*take not life which Allah (God) has made sacred*” (Qur’an 6:151). Although the Qur’an does not explicitly mention termination (Syed, 2009) religious figures can interpret this in many ways. However, if the Qur’an is interpreted where terminations are viewed as prohibited, women may want to be perceived as remaining obedient to their interpretation and consequently oppose alternative views.

Extract 4 illustrates that where there is uncertainty, dominant discourses play a key role in the social construction of knowledge, and is produced by effects of power and spoken of in relation to ‘truth’ (Foucault, 1972). The outcome of this is the maintenance of dominant discourses where truth is largely a patriarchal dominant interpretation of the Qur’an.

Zainab referred to other sources of knowledge that can be consulted for guidance about when it is acceptable to terminate a pregnancy:

Extract 5:

“...if a child has been given to you that has an illness then you should ACCEPT THAT (.) if (.) if (.) it’s gonna cause you harm (.) then (.) I (.) I ASSUME my religion DOES SAY that you can have an abortion in that respect (.) so I would go back to my (.) erm you know (.) Islamic teacher or scholar or whatever to find out what the (.) what the right procedure should be in that instance I wouldn’t just (.) JUST for my own happiness (.) and my OWN relief (.) get RID of a child because he has an illness (.) I just couldn’t do that”
(lines: 147-155).

The phrase “*I ASSUME*” suggests uncertainty of what is allowed and there is repetition and hesitation evident in Zainab’s speech. She also uses the imperative grammatical mood (“*you should*”) and suggests there is a “*right procedure*”, indicating there is no space for personal preferences (again seen later in relation to her “*own happiness*” and “*my OWN relief*”). Also, by deferring her decision to other sources of knowledge that can be consulted for guidance, she implies that importance should be given to religious figures and that their views should be sought. Zainab progresses from being uncertain to suggesting that the way to be certain is through seeking advice from religious figures. Furthermore, the use of the phrase “*get RID of*”, while suggestive of termination, also invokes a sense of unpleasantness and burdensome, something to be disposed of. She also shifts from viewing the pregnancy as “*a child*” to a gendered child (“*he*”), which perhaps attempts to personify the child, while also indicating the dominant cultural value of males in South Asian Muslim societies.

Zainab recognises the physical harm that can be caused by some pregnancies but does not articulate the possibility of psychological/emotional harm, perhaps because these factors are not viewed as significant. Zainab construes termination as immoral practice and she personalises the scenario to herself by saying that she could not “*get RID of a child*” if a child has an “*illness*”. She emphasises that there has already been consideration given in the Qur’an for when it is acceptable to terminate a pregnancy.

Views that are circulated and maintained reinforce religious ideas and have the impact of producing a ‘common-sense’ discourse, and conformity to the dominant religious discourse present amongst Muslims in relation to ToP. Consequently, women might be hesitant sharing an alternative view, because they fear being perceived as resisting religious ideas, which are viewed by many as a ‘truthful’ and ‘factual’ source of knowledge. Scriptural texts such as the Qur’an are viewed as the edicts of God and therefore, to question it, may be seen as challenging the edicts of God. These dominant discourses have the effect of constraining women’s actions and ensuring women conform to normative standards eliminating individual agency.

Similar to Zainab, Rizwana stated that she would never terminate a pregnancy for these reasons:

Extract 6:

“...if I was pregnant yeah and (.) I went to the doctors and the doctor said you know your child when it’s born it’s not gonna be right (.) everything is gonna be wrong (.) everything’s gonna be wrong with it (.) I don’t think that I would EVER get rid of that child I will NEVER have an abortion” (lines: 49-52).

Rizwana presents a dogmatic view. In extracts 1 and 2 she also shares very strong beliefs. Rizwana like Zainab does not articulate the difficulties of raising a child with significant difficulties nor does she consider the impact of the difficulties upon the child. Rizwana personalises the situation to herself and there is a change in her use of words from *“I don’t think”* to *“I will NEVER have an abortion”* which is perhaps aimed to give a more definite and absolute view. Furthermore, Rizwana suggests that what ever *“the doctor said”* it did not matter to her even if they said *“everything’s gonna be wrong with it”*. This medical discourse does not resonate with her hence she disregards it.

Rizwana’s strong views also imply that her actions are to be admired and perhaps because she would choose to accept a child with such difficulties, then God would reward her for accepting the challenge and keeping the child (also see extract 9).

These views reinforce religious ideas and highlight that ‘dominant’ discourses are circulated and maintained which centre on termination being viewed as prohibited and unacceptable under these circumstances.

Women’s perspectives have the impact of producing a ‘common-sense’ discourse, and conformity to the ‘dominant’ religious ideas present amongst Muslims. Women may be hesitant in sharing an alternative view, because they may fear being seen as resisting religious ideas, which are seen as

‘truthful’ and ‘factual’ knowledge. Scriptural texts such as the Qur’an are viewed as the edicts of God and therefore, to question it, may be viewed as challenging the edicts of God.

Many of the extracts shared highlight how discourse underpinning religion has regulatory intentions and result in regulatory outcomes. According to Foucault (1976) women conform to these ‘dominant’ discourses because knowledge is ‘constructed’ by the power inscribed in discursive practices. The discursive mechanism ‘commentary and authorship’ (Foucault (1972) is evident. Scriptural texts such as the Qur’an serve to limit, control and inform discourse through permitting Muslims admission to a ‘true’ commentary of an issue. For example, the way in which the Quran is mandatory reading to Muslims. According to Foucault (1972) the disciplines (e.g. Islamic school of thought) are a system of control for the production of discourse. To belong to this discipline, Muslims must abide by the principles set by the discipline. These findings illustrate that disciplines are responsible for generating and prohibiting certain discourses.

Deferment of responsibility to God

From the data, it appeared that the reasons for the occurrence of challenging life-events were placed in God and no pseudo-source of knowledge was accepted.

Zainab reported:

Extract 7:

“...if a child has an illness then you should accept it and think that its something from God...” (lines: 456-458).

Extract 7 highlights that according to Zainab, God is responsible for what happens and she proposes what women should do in this situation (“*should accept it*”). There is suggestion that because God has given this child with “*an*

illness” women should not question this or go against what God had intended. Through accounting for the illness in this way, minimises the amount of control women feel they have in decisions and diminishes their sense of responsibility. Raising a child who has any type of illness can be a difficult for families to manage but this is not an issue, which is again not spoken about.

Zainab also questioned why women terminated pregnancies when there was risk that the child would have a disability:

Extract 8:

“...if a child was gonna have Down’s syndrome or something like that then I (.) I feel that (.) GOD has (.) you know (.) that’s what god has prescribed for you so you should live with that CHALLENGE in your life why (.) erm (.) why would you not want to (.) NOT accept what god has given you....” (lines: 54-58).

Through accounting for the illness in this way, Zainab minimises the amount of control that she feels she has in decisions, which acts to reduce her sense of responsibility instead, deferring this responsibility to God. The words “*prescribed*,” and “*you should*” are imperative and suggest that raising a child with a disability is what God had intended and so women should not go against that wish. Also, although Zainab uses the word “*CHALLENGE*” to acknowledge this task, she does not articulate what this could consist of, such as the difficulties of raising a child with disabilities and the impact that the illness would have on that child. There is suggestion that if you fail this challenge then you have gone against God. There is also a noticeable shift from a personal realm to a religious realm suggesting that no one has the authority to challenge. In addition, the phrase “*why would not want to (.) NOT accept what god has given you...*” illustrates that Zainab does not accept alternative views.

A powerful discursive strategy in operation in extracts 7 and 8 is ‘normalisation’. There are messages communicated about what is the norm. For instance, what “*should*” happen in this situation and how women should

interpret this “*illness*” and respond. Women are positioned to internalise these ideas as a normative standard and there are expectations and pressures on women to conform to these views. This demolishes autonomy and instead produces homogeneity through processes of comparison and differentiation. There is an abandonment of power where women do not question or resist the ‘dominant’ discourse and instead, are perhaps submissive recipients of this discourse. This serves to silence and marginalise alternative views.

Another interviewee reinforced Zainab’s views. Rizwana reported:

Extract 9:

“I think it’s wrong they shouldn’t think like that (.) like I said you know if they think there’s something wrong with that child (.) its happened because of Allah [God] anyway” (lines: 142-144).

Rizwana suggests that it “*wrong*” to have an alternative view but also that this is problematic, as women “*shouldn’t think like that*”. She marginalises and dismisses alternative views and instead favours a religious discourse, which centres on God being responsible for whatever happened. Rizwana indicates that you cannot see it or feel it as something negative, which suggests that personal responses get shut down and there is no space for questions. For instance, Rizwana refers to “*something wrong with the child*” and “*its happened*” but does not mention articulate what this could be or the challenges it can bring.

During the interviews, participants spoke about being rewarded by God in the present and the after-life. Zainab spoke about being rewarded by God for raising a child with a disability:

Extract 10:

“...if you BELIEVE in god and religion and all that sort of thing then hopefully you’ll be REWARDED for that in your AFTERLIFE” (lines: 59-61).

Zainab's trust in God appears hedged, in her use of the word "*hopefully*," implying that what she has is hope, not a certainty. Also, Zainab's use of the word "*REWARDED*" implies 'putting up with something' so perhaps there is some suffering and challenges but this is not articulated.

Similarly, Hanifa spoke about losing her first child and understood this as God having this loss destined for her. Hanifa later had a healthy child and she believed that this was because she had "*HOPE*" in God:

Extract 11:

"...Alhamdulillah (praise to God) I'm ok (.) I have HOPE that God give me another baby and look" (lines: 268-269).

Interestingly, Hanifa does not speak about how the struggles of losing a child were managed.

Both Zainab and Hanifa demonstrate an external locus of control where they believe that God controls determines events such as pregnancies, the loss of a child or having an abnormal foetus with the risk of the child being born with disabilities. When women feel events are outside of their control, women may be placed in a position of powerlessness.

Zainab, together with other women, views God as having an influence in determining people's future. Beliefs such as these are communicated through discourse and can serve to encourage women to conform to the 'dominant' view. This is achieved through giving unity to ideas such as God presenting women with challenges and rewarding them in the afterlife for this.

Extracts 8 and 10 also suggest that raising a child with a disability is a challenge of faith and an opportunity to demonstrate strength when faced with adversity. Zainab and Hanifa share ideas of reward and afterlife and suggest a shared understanding of events amongst Muslims, which strengthens dominant discourses. These extracts perhaps imply (although not articulated) that if women did choose to terminate a pregnancy then they would be

punished for their actions, as they would “*NOT accept what god has given*” them (extract 8), the punishments for going against God’s wishes can serve to instil fear and facilitate conformity to the ‘dominant’ discourse.

Extracts 9 and 10 illustrate that discourses stemming from religion can have a profound and powerful effect on women’s beliefs, actions and practices. These extracts highlight how individual subjectivities are constituted in power relations and how ‘dominant’ discourses can make women resistant to other positions and subjugate them to normative standards. Extract 10 also implies that if women did choose to terminate a pregnancy then they would be punished for their actions, as they would be going against God’s wishes. These discourses act to influence women’s thoughts and actions; they can instil fear and through this facilitate conformity to the ‘dominant’ discourse.

Extract 11 illustrates that God is seen as responsible for positive and negative events that occur in Hanifa’s lives. Through believing that God will do good things for her if she has patience and has faith in God demonstrates she has external locus of control, and enhances conformity through strengthening ‘dominant’ discourses. Hence, women may try harder to conform to religious perspectives if they believe they will be rewarded with good things and punished for actions not approved by God. This places women such as Hanifa in a position of powerlessness where she views herself as having little control of their future because God is perceived as responsible for whatever happens.

These perspectives shared in the interviews highlight that women regulate themselves through drawing upon ‘regimes of truth’ underlying religious perspectives. These discourses have regulatory intentions and result in regulatory outcomes. Foucault (1976) proposes that individuals conform to a dominant discourse because knowledge is ‘constructed’ by the power inscribed in discursive practices. It is evident that scriptural texts such as the Qur’an, and people’s shared understandings, stemming from phallocentric interpretations, limit and control the discourse of women through only permitting them access to a ‘true’ commentary of an issue. For example, the

Quran is mandatory reading for Muslims and ostensibly seen as not subject to interpretation. Foucault (1972) proposes that the disciplines (e.g. Islamic perspectives) are a system of control for the production of discourse. To belong to this discipline, people must refer to a certain body of theory. The findings illustrate, as Foucault (1972) posits, that disciplines are responsible for not only the generation of discourse but also the prohibition of certain other discourses.

Devaluation of the medical profession

Muslim women who were interviewed favoured discourses underpinned by religious ideas above medical/scientific discourse. When speaking about prenatal tests some women reported that they would give birth to the child whatever the outcome of scientific tests or advice given by medical professionals, because of their religious beliefs. Rizwana reported:

Extract 12:

“...THEY [doctors] say that we’re preparing you (.) we try to prepare you for the WORST but we [Muslim women] don’t believe in that (.) we don’t need preparing (.) we say that whatever’s gonna happen it’s because of God isn’t it (.) if the baby’s gonna be like this (.) it’s gonna be because of God (.) God wanted it that way...” (lines: 477-481)“...I think once you’re pregnant once the baby’s inside you there is NOTHING a doctor can even or nobody can do (.) nothing you can’t do ANYTHING” (lines: 497-500).

Rizwana presents a very strong view and rejects a medical discourse (“we don’t believe in that”). She suggests that she and other Muslims do not care what the doctors say, as it is not relevant to them because they are Muslim. There is a sense of powerlessness, as Rizwana states “*nothing you can’t do ANYTHING.*” However, it is unclear whether Rizwana and other Muslim women see this as a problem as it is not spoken about. Perhaps, Rizwana does not feel subjugated and powerless through believing that God is supposed to have power. In addition, Rizwana states that doctors “*try to*

prepare you for the worst” but Rizwana appears to dismiss this and the challenges that it can bring through stating that its God’s wishes to have a child like this (*“God wanted it that way”*).

Rizwana views God as superior and indicates that scientific/ medical knowledge is useless because only God can help. By drawing on religious ideas the knowledge that produced is unquestionable and therefore, there is little space for resistance or counter discourse because it is suppose to be this way.

Rizwana also suggests that the advice given by doctors can be problematic as it can lead to women thinking about the consequences of having a child with an illness:

Extract 13:

“if you’re pregnant yeah and the doctor says to you that the child you’re carrying erm there’s something wrong with it (.) and you know that it’s gonna have like a long term illness or something yeah they’re just preparing you for it (.) it gets you thinking doesn’t it what am I gonna do afterwards with this child (.) how am I gonna cope with it...” (lines: 31-35).

This extract suggests that a medical discourse can be seen as a realistic position. The words it *“gets you thinking,”* suggest that if women take on a medical discourse then they will have to take on board what is said and have thoughts such as *“how am I gonna cope with it,”* perhaps a more realistic view. Rizwana again does not articulate what the difficulties might be although implies that there will be after the child is born. Rizwana also spoke about her sister-in-law attending hospital for scans:

Extract 14:

“I thought my god they did ALL these scans and what have they done (.) what have they DONE’ (lines: 413-414) *‘...every time she went for a scan you*

[doctors] made it worse for HER and for the BABY... (lines: 424-425).

Here, Rizwana shares an example where health professionals were unable to help (*“what have they DONE”*) and actually made things *“worse”*. Her example illustrates that there is very little professionals can do to help perhaps reinforcing her view that only God can help.

Rizwana reports how she perceives healthcare professionals:

Extract 15:

“...I don’t trust them” (line: 472).

The word *“trust”* implies confidence and faith and perhaps through viewing health professionals in this way a medical discourse can be rejected through perceiving it as false. Through dismissing alternative views as ‘false’ it strengthens a religious discourse, which is seen as *“true”*.

Similarly, Tasleem also does not offer credibility to a medical/ scientific discourse:

Extract 16:

“...obviously there’s never a 100% test that can definitely clarify you know if a child is going to be born in a certain way or not” (lines: 597-598).

Through Tasleem suggesting that there is no test with complete guarantee (*“never a 100% test”*) that the child would be born with a disability; she indicates that these perspectives can be inaccurate and are not informative. Therefore terminating when women are not absolutely certain would not be seen as acceptable. These ideas operate to strengthen discourses underlying religious ideas through constructing alternative views as subordinate.

These extracts illustrate that there is division and rejection where discourses

separate based upon assumptions and their perceived significance. For example, the importance placed upon God compared with anything or anyone else. This feature is related to the socially constructed divisions between what is seen as 'true' and false'. Foucault (1981, pg.62) refers to this as the 'will of truth'. There is acceptance of the creation of knowledge from religion, which is assumed to be free from human experience, and viewed as the truth. Therefore, alternative sources of knowledge (i.e. a medical discourse) are rejected because they are perceived as 'false'.

All participants reported that GPs are seen as the first point of contact for women obtaining a termination. However, two participants suggested that the advice given by GP's could be distorted because of the GP's own religious beliefs. Interestingly, Meena stated:

Extract 17:

"..my GP is an Indian woman (.) and she's religious and she BRINGS religion into things..." (lines: 654- 655).

This extract suggests that Meena's GP has taken on board religious discourses ("*she BRINGS religion into things*") perhaps through subtle pressures of cultural groups. However, it appears that Meena does not want a religious angle and is open to receiving a medical discourse.

These perspectives shared in the interviews generally highlight that Muslim women dismiss a medical discourse through either exclusion or marginalisation of this view. A medical discourse is presented as inaccurate and not necessary for Muslim women and instead women regulate themselves through drawing upon 'regimes of truth' underlying religious perspectives.

Culture

Participants drew upon cultural ideas, which included reference to social norms, and the expectations of the community participants identified with. Interestingly, the views and reactions of the community were important in how participants viewed termination. Discourses underpinning cultural ideas were identified and are discussed.

Fear, shame and guilt

Tasleem described how community members would be questioning of the decision made to terminate a pregnancy:

Extract 18:

“I think in most cases they’d probably would feel judged by that (.) it’s almost you know (.) why WHY there’s always those sort of questions of why (.) would arise from it and I think even if they weren’t judged they’d have the fear of being judged (.) and that will make them hold back as well” (lines: 504-507).

The words “*feel judged*” imply that there would be negative consequences for women because ToP is not seen as acceptable. The reemphasis of the word “*why*” suggests that there will be questions asked by others perhaps because they cannot understand the decision and do not agree with the decision. This also suggests that it would not be an individual act rather a collective view of others such as the family and the community. Interestingly, Tasleem suggests that women will “*hold back*” from making a decision that others would not approve of due to “*the fear of being judged*”. This illustrates how powerful this discourse is and how it operates to persuade women to conform to the ‘dominant’ view.

Although Meena did not identify with a religious discourse she did with a cultural discourse. There was a shared struggle evident amongst participants in relation to repercussions within the community for both Muslim and Hindu

women. Meena spoke about how the community would react to women terminating a pregnancy:

Extract 19:

“They’d just look down on you it would be SHAMEFUL” (line: 136).

The extract illustrates how people will react and the use of the word “SHAMEFUL” illustrates a meaning of judgement attached to terminations and that women are made to feel something for their actions.

Both extracts 18 and 19 illustrate the meanings attached to a termination. As a consequence women might feel embarrassed or humiliated because of how a termination is perceived. Therefore, women who consider a termination may be vulnerable because of the community favouring ‘dominant’ discourses where ideas define socially accepted practices.

Most participant’s referred to termination as taboo topic. Tasleem stated:

Extract 20:

“...it’s not something that’s ever really discussed it’s sort of (.) seen as quite a taboo subject ...” (lines: 30-32).

This extract suggests that the journey someone makes is taboo. Also because terminations are seen as shameful this compounds the idea that it is not something that can be openly spoken about. Therefore, alternative views are marginalised and silenced.

When speaking about the decision to terminate a pregnancy due to the risk of the child being born with disability, participants reported that the community would have difficulty understanding this decision for religious reasons. This highlights how cultural norms are enmeshed within religious ideas to produce a discourse of ToP. These sources are accepted as ‘truthful’ sources of

knowledge and together act as a powerful means for social control. Tasleem reported:

Extract 21:

“...I think for a lot of people (.) they see you know they see things happen from GOD (.) and you know if that’s come from god then you should deal with it (.) erm and I can imagine some people’s response would be that in the community as well (lines: 332- 336).... ‘there would be certain people in the community who would you know (.) be completely against it and obviously they’d be perhaps (.) a backlash towards it as well...” (lines: 340-342).

There are three ideas communicated in this extract. First, the sentence “people (.) they see you know they see things happen from GOD” implies that people should put up with things because it is God given. Second, the sentence “you should deal with it (.)... and I can imagine some people’s responses would be that in the community as well” suggests that people should accept it (child with disability) as it is from God and it is also what the community tells you to do. The term “backlash” suggests that if women do not put up with what God has given and go against the views of the community there will be consequences. Feelings appear to be pushed to the margins as terminations are construed as shameful.

Tasleem reports that some people in the community would be “*completely against*” terminations, which suggest that such decisions, would not be understood and supported. The usage of the term “backlash” highlights a strong negative reaction that women whose actions go against the community’s religious beliefs could expect. These ideas can create fear and function to prevent women from even considering a termination, and conforming to the dominant community’s view. Extract 21 illustrates that cultural norms are based upon religious ideas, which inform meaning, attitudes and practices. Religious ideas are accepted as ‘true’ and through the deployment of power inform and shape cultural discourse. This produces and strengthens ‘dominant’ discourses about ToP.

There was also some discussion during the interviews of the ways in which cultural expectations derived from religious perspectives can pressure women to obtain a termination. This can occur in instances where the pregnancy is a consequence of pre-marital sex. Zuleka, a GP, has witnessed this:

Extract 22:

“...a lot of these girls [South Asian women] are sort of very hasty and rush into terminations as a result of culture and religion...” (lines: 442-443)

This extract suggests that in some instances there can be a drive towards obtaining a termination. Zuleka implies that these decisions are quickly made and acted upon indicating a sense of urgency perhaps through fear of others reactions.

Zuleka reported an incident, which illustrates the effect that the community can have upon decisions:

Extract 23:

“...there was an incident that I sort of had to (.) deal with where a girl had become pregnant she was still fairly young and erm (.) the mum had been (.) was aware of it she wasn't married she had an Islamic background (.)so the fact that she had sexual intercourse before marriage you know (.) that was gonna set off a whole new erm (.) whole new issue with the community so it was the mother that had brought her in for the termination” (lines: 384- 389).

Participants reported that Islam has guidance on when it is acceptable to terminate a pregnancy. However, in circumstances where premarital sex has taken place, Zuleka reported that families fear the reactions of others and terminate the pregnancy in secrecy. These actions imply that there are fears of stigmatisation and social exclusion, which may result if the pregnancy is *not* terminated, even if this act itself is proscribed by their religion, thereby creating a hierarchy of ills and repercussions. Extract 10 indicates that there

appears to be a conflict of people needing to decide which of the two evils is greater: others' knowledge of a woman's ToP or premarital sex. This therefore forces people to choose which act, if it became public, would have the worst repercussions for the woman and the honour of her family. Extracts 22 and 23 illustrate that dominant discourses prohibiting terminations are disregarded in favour of pre-marital sex discourse perhaps, because the consequences are far greater and immediate in this life rather than the punishment from God in the life after.

These extracts also illustrate how power operates through discourse and informs women's actions. Muslim participants reported that Islam has clear guidance on the circumstances upon which it is acceptable to terminate a pregnancy. However, there appears to be trade-off between religious beliefs and the reaction of the community where premarital sex has taken place. Although both are sinful, perhaps in the 'here life' the consequences for premarital sex carry far greater consequences for families. In Zuleka's experience, families place pressure on women to obtain a termination if the pregnancy is outside of marriage. Zuleka suggests that this is because families fear the reactions of others in the community because of their religious beliefs. These actions are hidden from the community the family belong to, because of the feared consequences. Perhaps families fear that they will be stigmatised and socially excluded.

Many participants spoke about women regretting their decision to terminate and experiencing guilt for a number of years after. There was also discussion that some women later developed mental health difficulties. Interestingly, women felt that it was likely that these feelings occurred because a termination went against their religious beliefs. Zuleka shared her working experiences:

Extract 24:

"...there's an element of a GRIEF reaction once they've [South Asian women] sort of been for the termination because...they'll feel like they're ending A

LIFE...some of them go onto erm (.) having sort of mental health problems where their mental health gets worse because somewhere they feel really guilty as a result of the termination ... I think at some point the guilt will come in because religion will be mentioned" (lines: 361-362).

This view contrasts other women's views in the interviews where suffering and pain was largely ignored. The term "*GRIEF*" perhaps refers to guilt caused by religion for having the termination. There appears to be suffering in women, which might be ignored because the challenges are not acknowledged. Zuleka reports that "*guilt*" is experienced because of "*religion*". This suggests that there can be emotional and psychological consequences for terminating pregnancies (or even continuing with a pregnancy when women feel they have to conform for religious reasons) but these are largely not spoken about.

Zuleka later added:

Extract 25:

"...usually the women that won't go ahead with terminations (.) for whatever reasons you know (.) the end point will be (.) I will be frowned upon this as a result of religion" (lines: 367-369).

This suggests that in Zuleka's experience women perceive religious ideas as the 'truth' and feel that their actions would be going against the community's values and also God's wishes. Women may fear the repercussions of this and therefore "wont go ahead with terminations."

Extract 25 illustrates how dominant discourses can be internalised as normative standards, which act effectively to create conformity (Foucault, 1972). Women who go ahead with a termination may be seen as resisting the subject position of a 'Muslim' and challenging social practices, structures and power relationships (Burr, 1995).

The family system, marriage and motherhood

All participants reported that their family had significant involvement in their lives and that marriage and motherhood are seen as important within the religion and/or culture participants identified with. Tasleem reported:

Extract 26:

“...I think with most sort of Asian families (.) there is sort of BIG INFLUENCE from external family members or extended family members as well (.) and I think sometimes people sort of rely on a little bit more or allow people (.) other people to make their decisions for them as well...” (lines: 391-394).

The phrase “*BIG INFLUENCE*” suggests pressure and that women would be unlikely to be able to make a decision alone because in some communities “*extended family members*” views are taken on board. This perhaps reflects the structure of some South Asian families. Tasleem does not state exactly who the “*other people*” are, perhaps it is family members who are positioned hierarchically within the family system and those who may have religious knowledge and/or life experience. It appears it is these “*people*” who hold some power as they can make women’s decisions for them. Tasleem does not speak about any problems with this nor any potential distress produced by this. Zainab suggested that terminations are a rare occurrence and a taboo subject because cultural norms centre on getting married and starting a family:

Extract 27:

“...in my own family I’ve never come across anyone who’s (.) HAD to have an abortion so (.) I mean it’s always been about get married have kids (.) you know you don’t talk about abortion...” (lines: 233-235).

The terms “*HAD to have an abortion*,” suggests that terminations are a last resort and only occur on rare occasions. Zainab indicates that there are

cultural and/or religious norms, which centre on getting married and then having children. Having a termination does not fit in with these ideas and so is excluded from talk (“*you don’t talk about abortion*”). This acts to reinforce ideas that terminations are taboo and that it is shameful practice.

There is also indication that there are cultural expectations enmeshed with religious ideas (“*get married have kids*”) which women might feel pressured to fulfil. It seems less likely that there will be resistance to religious and cultural ideas, which are reinforced by the family system and accepted by significant others, as trustworthy. Zuleka explained how women’s views could be influenced:

Extract 28:

“I think their family would be a big influence (.) family and when you think about the families view they’d think about the community, who’d think about religion (.) so I think it’s a bit of a domino effect...” (lines: 338-341).

This extract suggests interconnections between systems where the family are part of the community who have religious views therefore; the family also need to take on these views to be accepted by the community. The family then puts these views forward and have a “*big influence*” on decisions. These views were also supported by Tasleem (see extract 21).

The expression “*domino effect*” suggests a chain reaction where there are causal linkages between each of these systems. Hence, if women do not follow religious perspectives, the community would be unhappy with the family who would then be unhappy with the woman. Therefore, it is the responsibility of the woman to respect religious ideas to ensure there are no repercussions.

Here a religious discourse is infused with power as it is viewed as most superior. Community norms and family values are derived from religious ideas, which control and inform discourse. This discourse has regulatory outcomes for women, families and the community.

Some women spoke about the role of women within the family system. Riwana felt that women were not being able to make their own decision:

Extract 29:

“...they’re pressured aren’t they by their husbands (.) family mostly I think women are more pressured with their husbands and mostly their family as well like in-laws and everything (.) yeah I think they’re involved as well” (lines: 89- 92).

The words “*husband*” and “*in-laws*” suggest a patriarchal family system where women’s husband and parents make women’s decisions. Rizwana indicates that there are traditional gender roles within the family system in South Asian communities. This reflects a patriarchal system where the role of the male as the main authority figure and head of the family is crucial to social organisation. The word “*pressured*” is used twice to emphasise the point and although the word implies distress Rizwana does not articulate this. It appears that in this environment women would be able to make their own decision and there seems to be a lack of support available, which can have the potential to produce psychological distress and poor health outcomes.

Similarly, Meena suggested that in-laws make decisions for the family she stated:

Extract 30:

“...it would probably be MORE their decision than your husbands (.) because they’d (.) especially if your living together you know they’d probably make the decision for you” (.) ((laughs)) (lines: 440-443).

Again, this reflects a patriarchal system present in some South Asian communities. The extract implies that there are still some families “*living together*” and that there are distinct roles for men and women, which appear to be accepted. Meena laughs whilst stating that in-laws would probably

“make the decision for you” suggesting that she does not support this view and perhaps also ridiculing this view. It is not clear how women would react to the involvement of in-laws in decisions and the impact that it can have. This also has the potential for secrecy in instances where women make their own decisions, which go against family values, cultural norms and religious beliefs (see extract 31). In circumstances where in-laws are aware of the pregnancy women may feel that they have to accept the decisions made by their in-laws. This is because of how women’s role is understood. Women are unlikely to be in a position to resist practices arising from ‘dominant’ discourses.

Zuleka spoke about how women were viewed within the community:

Extract 31:

“you know I think as women as you grow up there’s a list of what you can and can’t do (.) and I think when people BREAK from the do’s and don’ts (.) erm there’s a lot of backlash as a result of that in communities” (lines: 305-307).

Extract 31 is powerful in illustrating the pressures to conform because of fear of *“backlash” from the community*. There are also demands placed upon women that specify what they are and are not allowed to do. This leaves women little room for women to manoeuvre. The word *“list”* implies that it is constructed by someone and is created specifically for women. It is likely that men construct this “list” because as mentioned earlier it is men who provide the interpretation of Islam and bridge the gap between religion and the community.

This discourse has regulatory intentions and results in regulatory outcomes. Through productive mechanisms this discourse influences perspectives and practices and produces conformity to this ‘dominant’ view. For Foucault (1972), discourses that are preferred and legitimised operate to communicate meaning and preserve dominant ideologies. Non-conformity may be viewed as a rejection of the cultural norms and religious beliefs of the community.

Some women spoke about children being important within marriage. Tasleem like Zainab referred to cultural expectations to have children:

Extract 32:

“...that’s one of the core reasons for getting married (.) and sort of reproduction is seen as you know a big sort of thing to be thinking about...”
(lines: 233-234).

It is evident from this extract that “*reproduction*” is perceived as a key feature of a woman’s role (“*core reason for getting married*”) although children should only be born within wedlock. There is indication that the purpose of getting married is to have children and it was previously discussed that pre-marital sex did not make sense and was not accepted by the community because of religious beliefs (see extracts 22 & 23).

Extract 32 suggests that women may find it difficult to avoid taking on the role of the mother because it is seen as part of a woman’s identity. This position may be seen as the most significant role for women and may give rise to status in the family and community. Therefore, motherhood may be seen as devalued by women who obtain a termination and women may be perceived as rejecting social and cultural norms and religious beliefs.

Ideas such as these, illustrate how discourse is productive and the ways in which discourse ‘hook’ into normative ideas and common-sense notions. For instance, by suggesting that children are a significant part of marriage, ToP and pre-marital sex and children outside of marriage are constructed as taboo, shameful and wrong.

Interestingly, Meena shared her views on what she thought would be her parent’s reaction to a pregnancy outside of marriage:

Extract 33:

“...if I got pregnant right now unmarried my parents would kill me (.) you know they’d be no way that I’d ever have a child outside of marriage...” (lines: 97-99).

Meena emphasises that a pregnancy outside of marriage would be a major event because it is not seen as socially acceptable. The words “*would kill me*,” suggest that the consequences for Meena by the family would be great and that because she knows this she never do this. The extract illustrates how subtle discursive structures give rise to and constrain particular ideas, attitudes and practices. Meena appears to suggest that sex is considered a deviant activity outside of marriage and therefore a child born outside of wedlock would not be seen as acceptable.

The discourse within the family system and the community about women getting married and then having children has regulatory outcomes where women conform to this view.

Zainab shared her experience of what happened to a family member who became pregnant outside of marriage.

Extract 34:

“... I think because marriage is so important in our religion...and what I HAVE SEEN is where someone has got pregnant in my family they’ve got married straight away...” (lines: 363-366).

Again, another interviewee shares that Islam views marriage as “*important*” and indicates that marriage should be the basis for sexual relations and motherhood. Religious ideas inform and influence cultural attitudes and practices and it is important to be seen as conforming to these views.

Getting “*married straight away*” suggests urgency in order to prevent the community being unaware that the pregnancy has taken place outside of wedlock. These actions may prevent rejection, stigmatisation and social isolation.

These extracts illustrate that the family system is influential in women’s decision but also that the community and religious beliefs are also important. Ideas of marriage and motherhood are not consistent with obtaining a termination and therefore it is constructed as an immoral act.

The religious discourses women drew upon have the impact of specifying cultural and social norms within the community women identified with. These norms were important in facilitating and restricting women’s actions according to, what is viewed as acceptable at that time. Discourses suggesting feelings of fear, shame and guilt, the influence of the family system and ideas of marriage and motherhood together with, discourses underlying religion had the impact of constructing termination as ‘bad’, ‘wrong’ and ‘immoral practice’.

The ‘dominant’ religious discourse interacts with these other discourses, which helps to maintain conformity and also, has the effect of marginalising and silencing alternative views.

Summary

The construction of ToP through the discourses identified creates cultures, practices and context specific realities. Discourse through language and the meaning attached to language produces particular effects- it constitutes decisions to terminate a pregnancy as immoral. This is achieved in many ways using several discursive mechanisms. For example, through viewing motherhood as significant and ‘normal’ and viewing children as ‘natural’ within marriage and as ‘a gift from God’. Discourses about termination draw upon cultural and religious ideas and this interacts with, and was mediated by other discourses about family, and sexuality, which produces ways of conceptualising termination. These discourses link into normative ideas and

common-sense notions where motherhood is seen as 'normal' and 'good' and premarital sex as deviant behaviour.

The discourses identified illustrate that taken for granted sets of ideas about who and what exists in the world help to impose bounds beyond which it is often very hard to reason and behave. When particular relationships become understood as common sense, they set limits to the cultural know-how of a particular social group.

Step five- Identifying Inconsistencies

This stage identified and explored inconsistencies in the data. Foucault (1972) understood dominant or common sense understandings as discursive structures. He suggests that while discursive structures may appear eternal, fixed, and natural because they are embedded within different social networks they are fragile and continually ruptured. Hence, there are always possibilities for meanings, attitudes, and practices to change to be challenged. Therefore, this stage involved identifying contradictions and ambiguities within the interview data.

Despite most women reporting that they would not terminate a pregnancy because the child was at risk of being born with disabilities for religious reasons, Zainab shared her experiences of people's reactions to a child with a deformed foot:

Extract 35:

"my sister's child she has a deformed FOOT erm (.) and a lot of people (.) think that's a bad thing (.) they think (.) why does she have that foot you know (.) is she being punished ... she doesn't have TOES doesn't mean my sister should have got rid of her' (lines: 276-282)' Even my sister because people were saying things about her foot made her feel really BAD (.) it made her feel as if she's being punished" (lines: 283-285).

This extract illustrates some ambiguity in what Muslim participants reported. For instance, Zainab reported that a disabled child should be accepted because it is a gift from God (see extracts 8). Zainab reports that people view a “deformed FOOT” as a “bad thing” and that it is seen as a punishment. This suggests that people’s views are ambiguous as there are suggestions that Zainab’s sister has done something wrong and that she is being “punished” by God. These views had an impact on Zainab’s sister as she began to feel “*as if she’s being punished*”. Hence, if women feel they are being punished then they might try harder to conform to their religious perspective through fear of being further ‘punished’. This can act as a method of social control.

During the interviews participants discussed their feelings of obtaining a termination in circumstances such as: being in an unstable relationship, being a single parent, the age of conception and terminating a pregnancy for financial reasons. Tasleem reported:

Extract 36:

“...it still comes back to that thing (.) of a LIFE (.) and you know (.) you know it’s getting rid of a life (.) and for me that’s quite sort of it’s a difficult thing to sort of accept (.) I do totally agree that you know (.) that it’s a woman’s choice ...” (lines: 535-538).

This extract reflects Tasleem thoughts and illustrates that she takes up the subject position of a Muslim and sees the world from this perspective. Tasleem views the foetus as a “*LIFE*” and a termination as “*getting rid of a life*.” The language and ideas used to construct terminations reinforces the ‘dominant’ discourse. On a superficial level, Tasleem reports that she would be able to understand others decision to terminate and supports the idea that “*it’s a woman’s choice*” perhaps, not to appear judgemental.

Throughout the interview with Hanifa she maintained that termination was unacceptable (other than if the mother’s life was endangered) because Islam prohibited this. However, Hanifa spoke of her mother making the decision to

terminate her sister-in-law's pregnancy in Pakistan and Hanifa agreeing with this decision. The family appear to view the doctor as responsible for the decision made which perhaps defers the family's sense of responsibility:

Extract 37:

"...when the doctor said to my mother (.) and she said it's ok (.) you can do it (.) and we tell her everything explain everything to my sister-in-law (.) that what happened with you (.) in that time (.) and we decided to do (.) abortion" (lines: 71-73).

Hanifa spoke of her sister-in-law being in a lot of pain and the doctor informing them that because of the heavy blood loss the baby would be born with disabilities. Hanifa reported that the doctor said "*it's ok (.) you can do this*" and the extract indicates that a medical discourse was favoured on this occasion, over religious and cultural discourses. The word "we" suggests a collective decision made on behalf of the pregnant woman. The extract also indicates that it is the husband's family who made the decision to terminate the pregnancy.

Hanifa later in the interview went back to this event. She reported:

Extract 38:

"I think so you know in our religion it's not" (lines: 100)... "you know my mother's (.) she's not educated (.) and her sister with her (.) and we both decided that we had abortion" (lines: 166-177).

Hanifa indicates that she knows terminations are not permissible in her religion and stipulates that because the doctor is educated (and her mother is not) the family have taken the doctors advice and this perhaps, justifies the decision made:

Extract 39:

“...they don’t have awareness about abortion (.) and they don’t have awareness about (.) WHAT our Islam says about these things...” (lines: 144-146).

Hanifa suggests that the family do not know with certainty what Islam stipulates in these specific instances. Hanifa’s account reflects inconsistencies where conformity to the ‘dominant’ view is ruptured and a medical discourse is preferred.

There were also occasions where women drew upon cultural ideas despite emphasising the importance of their religious beliefs, which demonstrates the competing nature of disciplines.

There was discussion of alternative discourses being more influential in functioning to pressure women to have a termination. Zuleka, shared her experiences:

Extract 40

“I think families play a big part...I’ve certainly seen terminations go ahead (.) as a result of family members” (lines 376-377).

Islam forbids premarital sex and extract 23 indicated that women might be labelled with negatively valued concepts, which may have implications for the family. Extract 40 implies that the family appears to pressure unmarried women to terminate a pregnancy, despite these actions being inconsistent with the family’s religious beliefs. This perhaps occurs in response to fear of the community’s reactions, which is more influential than religious discourse prohibiting terminations.

These extracts illustrate that people make distinctions between life on earth and life after death. Although both sins are problematic in the afterlife, ToP will

at least not alienate people from their communities if kept secret, and therefore be seen by the family, perhaps as the lesser of two evils. Terminations can be kept hidden, pregnancies cannot.

Foucault (1972) argues discourses that are preferred mobilise meaning and maintain dominant ideologies. Dominant discourses are perceived as normative standards, which operate to create conformity (Foucault, 1972). Non-conformity challenges social practices, structures and power relationships (Burr, 1995). Extract 23 suggests that women take on the role of subjugating themselves through the process of being evaluated and judged in comparison to social norms. Through participation in the social environment women come to internalise normative standards, which work powerfully to produce conformity to discourses which are most influential (Foucault, 1972). In this case, pre-marital sex discourse is more influential because women know and fear the consequences of this. Therefore, women feel pressured to terminate in these circumstances.

Although a discourse prohibiting terminations was evident, Rizwana reported that there were additional circumstances where women would consider ToP:

Extract 41

“...some women... their husband wants a BOY right and erm (.) they’ve said like if you don’t have a boy this time (.) we’re gonna you know (.) obviously that child’s not gonna be born (.) and then obviously when women go to the doctors the first thing they want to know is if it’s a boy or girl don’t they and if they know it’s a girl what do they do (.) they’ll go and have an abortion” (lines: 76-82).

Extract 41 illustrates that there might be occasions in the conflicting discursive field where women engage in practices, in which ‘dominant’ discourses are challenged. Rizwana suggests that this challenge might occur in instances where women face pressures from their husband, to conceive a male gendered child. In these instances, Foucault (1972) posits that knowledge is

created as a product of complex interactions among struggling and competing sectors. The amount of power an individual holds is directly related to their ability to engage in various dominant discourses that shapes society. In this case, there may be cultural norms steering decisions where there is a prevalent discourse of the community preferring a male child. This practice challenges the existing discursive structure where common-sense understandings of terminations being prohibited are disregarded.

There is also importance attached to the “*husband*” figure and what he “*wants*” and an indication of pressure to please him. The statement “*if you don’t have a boy this time*” suggests that the woman is responsible for achieving the desired outcome. Reference to “*abortion*” is deferred in talk and instead Rizwana uses the phrases “*you know*” and “*don’t they*” to co-opt the interviewer into a shared/common discourse reflecting cultural ideas and experiences.

Stage 6- Identifying absent presences

According to Foucault (1972) silences operate on at least two levels. First, silence as discourse is a reminder of how speaker’s subjectivities are created within discourses. Who has the right to speak or is portrayed as in authority is itself constituted through discourse. Second, Foucault’s ideas illustrate how a privileged/dominant discourse operates to silence different understandings of the world. Of vital importance are Foucault’s arguments concerning the intersection between power, knowledge, and persuasion. According to Foucault, silence surrounding a particular topic is itself a mechanism of social power within established structures.

Becoming alert to silences was challenging for the researcher as it consisted of being able to interpret the transcripts for what was omitted from the interviews. To achieve this, research was conducted into the broader social context of the project to develop awareness of the existence of various social structures that constrain what is present in the data.

Absence of challenge to patriarchal views

As discussed in the journal paper, Muslim participants view the Qur'an as the most important source of their knowledge and not containing any errors, absences or contradiction. However, 'truth' is a patriarchal interpretation of the Qur'an as Muslim participants indicated that in Islam, religious leaders, scholars and mosque Imam's, all of who are men, advise on personal matters propagating patriarchal views. However, the influence of patriarchy on the interpretations of the Qur'an was not articulated during the interviews. Muslim women appeared to accept men's interpretation of the Qur'an without resistance to patriarchal views.

Absence of legislation

An assumption was made by the researcher that participants were aware of the legislative criteria for obtaining a termination in England. However, only one participant made direct reference to legislation. Zuleka, perhaps because of her medical background had knowledge of the legal criteria, methods and services available for terminating pregnancies and shared this during the interview:

Extract 42:

"...it's legal in this country under 24 weeks erm (.) in terms of (.) there's different methods of termination of pregnancy (.) erm essentially there's a criteria for when or why a mother can terminate so erm (.) that would be because of erm (.) if continuing with the pregnancy would effect mum's mental health erm if there is gonna be a detrimental effect on her existing children (.) because of her mental health or is there's abnormalities in the unborn child..."
(lines: 20-26).

Participants may not have mentioned legislation because they did not know the legislative criteria. However, it is also possible that participants did not agree with termination being permissible under the conditions specified by

law. Instead, a religious perspective is preferred and presented as having authority. Through dismissing alternative views, ideas underpinning religious discourse are strengthened and accepted as 'true'.

Absence of multiple Islamic perspectives

As described in the literature review, there are various schools of thought in Islam representing multiple perspectives. Interestingly, participants specified their trend of thought and expressed similar readings of texts along with the doctrinal and social attitudes but other perspectives were not spoken about. Perhaps this was because participants wanted to present a 'truth' that was not compromised through various interpretations being possible.

Only one woman Zainab, made reference to the different trends in Islam:

Extract 43:

"... in every religion there is something that can help you and for ME the SUFISM side has helped me out of those situations so (.) so (.) and it's a more liberal (.) view of religion as well (.) it's not so HARD CORE...it was not very flexible (.) so like the Sulifism side..." (lines: 196-200)... 'Sufism you follow (.) erm (.) spiritual guides in Sulifism you follow scholars more erm (.) I mean I like the scholar side as well but I like the Sufism side as well so I wouldn't say I am (.) one or the other I just call myself a Muslim..." (lines: 196-207).

This extract suggests that some Islamic perspectives are more liberal and others more traditional. It appears that participants were aware of the distinctions between Islamic perspectives but most chose not to mention this. Instead, more traditional perspectives were evident during the interviews where Muslim participants referred to scriptural texts including the Qur'an and Sunnah. This acts to unite all Islamic perspectives together and present a more universal view of Islam, one that is authoritative, superior and 'true'.

Absence of the voices of others

It became evident during the interviews that Asian/Muslim's were viewed as a superior group and other ethnic groups were racialised and stereotyped. When referring to whom Rizwana felt obtained terminations she stated:

Extract 44:

"...well mostly English DO this [terminate pregnancies] but I think now OUR Asian women they have started to THINK more..." (lines: 47-48).

This suggests that the way "*English*" people think is problematic. However, no further detail is given about what this group actually think or how "*Asian*" women may be becoming like "*English*" women. However, Rizwana indicates that this change is problematic. Perhaps alternative views are absent because participants see these views as having no credibility and are invalid accounts hence not worthy of discussion.

Also, when speaking about family involvement in decisions to terminate Rizwana reported:

Extract 45:

"I think that this [involvement of family members] happens mostly in Asian (.) Asian communities not more in English as English are not that bothered are they" ((laughs)) (lines 93-94).

Rizwana distinguishes between "*Asian*" and "*English*" communities and appears to disregard "*English*" people's views. Rizwana suggests a careless attitude by the "*English*" and implies that they do not seriously consider their decisions and therefore, she does not give their voices any integrity. She is dismissive of alternative views and this works to silence others views and reinforce Islamic perspectives.

Absence of women's emotions

Throughout the interviews participants suggested that women experience challenges, judgement and fear (for examples see extracts 8, 10, 11, 18, 19, 21, 23, 24), which has the potential to cause distress. However, participants do not openly speak about these issues. Zuleka is a GP and has witnessed mental health difficulties following terminations (see extract 24). She suggests that guilt is produced because of religion and that this causes suffering in women. However, the psychological or emotional impact on women is not articulated. This is significant, as women may not feel that their difficulties have been acknowledged and therefore their suffering appears to be ignored which has the potential to cause women pain.

Stage seven- Identifying Social Contexts

In the literature review the researcher detailed the background to ToP. Specifically, she discussed the legislative criteria in the UK, the interventions available for women undertaking a termination and the prevalence of termination in the UK. Also, as the majority of participants described themselves as Muslim the researcher considered the construct 'ToP' within a religious context. Hence, this information is not repeated here. This stage considered the social production of the data, its authorship, technology and intended audience.

Historically, religion has provided society with information about sexuality, which numerous societies have employed to generate laws regulating sex. Some societies have 'relaxed' these laws perhaps in response to social and demographic changes whereas other societies laws and practices continue to be informed by religion.

In this study, women's beliefs and practices were predominately influenced by the Qur'an, male religious figures, women's husbands and families, and the community they identified with. Women tended to view themselves as submissive recipients of this discourse and this produced subject positions for women, which they identified with, without recognising their own role in

propagating the very discourses that serve to restrain their choices and freedoms.

The researcher attempted to understand the meanings associated with termination and identify the social conditions and practices that have contributed to women's perspectives.

The researcher noticed that there were various subject positions women adopted. The majority of women adopted the position of being a 'Muslim woman' and conceptualised the construct 'ToP' in relation to religious ideas. Motherhood was associated with a Muslim woman's identity and perceived as an important role to fulfil. Through the use of this subject position, Muslim participants cited many reasons for why women should not terminate including human values, religious and cultural beliefs and values of conscience. These ideas were portrayed from the subject of a Muslim woman and invoked ideas that termination was wrong and challenged social, cultural and religious norms. By subscribing to discourse against ToP, participants also adopted the position of being a 'good Muslim', as someone who upheld the status quo.

There were also some women who took up the subject position of being a 'mother'. Participants reported that religion and culture view the role of a mother as 'natural' for women and therefore, terminations are seen as devaluing motherhood. Participants articulated that within their community the cultural norm was to get married and then to have children. Furthermore, Islam places emphasis on marriage and greatly values the life of a child. Most women accepted these ideas and this highlights that certain language and meaning attached to language can produce discourses that create cultures and traditions and context specific realities.

All women adopted the subject position of being a 'community member'. Participants reported living in close-knit communities where ideas about termination not being acceptable practice and a taboo subject area, are circulated. Participants reported that the community they belong to produces

fear and this can have the power of either not terminating a pregnancy or obtaining a termination in secrecy. This illustrates that women's perspectives have been developed and reinforced by cultural norms that originate from male-dominant religious discourse.

These findings are particularly relevant to Foucault's (1976) theoretical ideas, which suggest that power has a productive aspect to it. Not only does it prevent us from doing certain things, it also produces certain behaviours. This indicates that the social contexts within which discourses arise are important and through the circulation of power and knowledge people adopt subject positions usually consistent with the 'dominant' view.

Part Four: General Discussion and Reflections

4. Section Introduction

This discussion section summarises the findings of the current research and discusses this in relation to the theoretical framework applied and existing research findings. There is also consideration of the implications and limitations of the research and suggestions are made for future research. Lastly, there is a reflexive section, where the researcher considers the various stages of the research process.

Findings summary

This study found that most participants constructed ToP using discourses specifying knowledge and truths. These discourses provided participants with a frame of reference, a method for interpreting the world and giving it meaning. In particular, knowledge and 'truth' about termination was socially constructed in relation to religious and cultural discourses available. This knowledge was then produced by the effects of power and spoken of in terms of 'truths'.

Through suggesting that discourse influences how women think and behave does not mean that women are submissive recipients of this discourse. As previously illustrated, these discourses were to some degree contested and challenged and therefore not necessarily omnipotent. This study highlights that discourse interacts with, and is mediated by, other discourses to produce a way of presenting an issue. For example, discourses of motherhood, children being a necessary part of marriage and a gift from God interact with, discourses prohibiting termination in Islam and these discourses construct a 'dominant' discourse of ToP.

Theoretical framework

In relation to Foucault's (1972) theoretical ideas, these findings illustrate that the effect of truth is a power-laden process through which particular knowledge is deployed from discourses as a mechanism for social control. This highlights that discourses are situated within social networks in which groups are empowered and disempowered in relation to one another. A consequence of discourse is the favouring of powerful social groups (those who identify as Muslims), where Islamic perspectives including scriptural texts are preferred over other perspectives and seen as sources of 'truthful' and 'factual' knowledge. Women's views demonstrate how less favourable sources are marginalised and silenced as they are positioned as untrustworthy. These findings illustrate that discourses of ToP produce effects- discursively and through practice- which influences the way women understand, experience, and respond to a termination.

Current research and previous findings

Lipp (2009) suggests that some women might experience negative psychological consequences following a termination. This study offers some support for these findings. There is indication that some South Asian women may be at risk of experiencing negative psychological reactions or poor mental health when considering a termination or following a termination. This is particularly likely in circumstances where a termination is obtained but this,

conflicts with women's religious and cultural beliefs and those of others around them. Women indicated that there would be limited social support available in these situations. All of these factors have previously been identified to predict negative psychological consequences following a ToP (Bonevski & Adams, 2001).

Women in the present study reported that are pressures from family members, usually to keep the child. This has the potential to produce psychological distress, as women may feel unable to make their own decisions. Some women also reported pressures to conceive a male gendered child. In these situations, participants stated that they have witnessed women feel pressured by their husband to terminate the pregnancy. This is problematic because Broen et al. (2005a) found that the strongest predictor of emotional distress was pressure from a male partner to have a termination.

In situations where women continue with the pregnancy despite women's own preferences, social disapproval and rejection may be feared and this has the potential to cause an adverse effect on women's mental health. In these circumstances women may continue with the pregnancy because of these pressures or may chose to terminate the pregnancy. However, it is likely that if women terminate a pregnancy they are likely to conceal their circumstances from family and friends because of the shame associated with the termination (Major & Gramzow, 1999). Therefore, women may be left to cope alone after the procedure.

Some women also reported that family members pressure women to obtain a termination in circumstances where the pregnancy is outside of marriage. The pressures to terminate because of feared reactions of the community women belong to, indicate that limited social support is likely to be available. This might trigger negative psychological reactions in vulnerable women. This is particularly significant because supportive partners or parents improve psychological outcomes for women (Bonevski & Adams, 2001). These findings highlight that social support has a significant influence on women's

experiences and can improve psychological outcomes following a termination. However, limited social support is likely to be available in South Asian communities under these circumstances.

All Muslim women reported that they would not obtain a termination in circumstances where the foetus has severe congenital abnormalities. These findings differ to a study conducted in Pakistan (Arif et al. 2008) where, almost one quarter of the sample investigated, reported that they would consider a termination in these circumstances. However, in Arif et al's study the reasons for participant's decisions were unclear. The findings of the current support Ahmed, Green and Hewison's (2006b) study, which suggests that there are religious and cultural influences on women's attitudes.

Implications, Limitations and Future Research

The findings of this study illustrates the complexities of the relationship between ethnicity, culture, religion and ToP, and recognises the need to understand both ethnic and religious group membership when considering health implications. It is evident that religion and culture operates, as an important foundation for how women understand ToP and that there are causes and consequences of such affiliations.

Group membership is significant however, decisions may also need to be individually based and occur in the context of broader social relationships. Typically, health professionals when viewing a religion rely upon one model of a particular religion but even within one sect there is heterogeneity, but this is not appreciated within the view of literature. South Asian women may subscribe to a particular doctrine but intergroup variation is not accounted for in this literature. The findings of this study illustrate that it is not simply the mere affiliation with a category that is important but also the degree of investment (emotional, behavioural, social) with the category, which will affect attitudes, beliefs and practices. For example, there are those who subscribe to a religious framework and those who identify but do not subscribe. These findings highlight that health professionals need to be culturally competent in

order for them to recognise these distinctions and help determine how women view reproductive health issues rather than, the mere labelling of self-identify with a religious or ethnic category.

These findings also suggest that South Asian communities may be a source of negative attitudes and discrimination towards women who consider or obtain a ToP, or engage in premarital sex, both of which can result in social exclusion. Hence, South Asian women who find themselves having transgressed their community moral codes might be at increased risk of emotional distress and may benefit from psychological support, which recognises these complexities of membership, alienation and expulsion prior to or following a ToP.

Studies indicate that in healthcare professionals are not comfortable discussing religion and spirituality (e.g. White, 2009). In addition, Plante (2007) proposes that a large proportion of psychology programmes exclude spirituality and religion during professional training. Hence, it is likely that psychology professionals/clinicians do not develop adequate competence to work with religious and spiritual clients.

These findings suggest that clinical psychologists should be mindful of affiliations and belief systems women hold and be aware of power differentials and agency among women. Training clinical psychologists to understand the essential principles of a religion, on which attitudes, cultural norms and practices are based upon is necessary, as this might help understand reproductive health decisions better, and perhaps minimise the replication of cultural biases and prejudices that can exclude minorities and reinforce inequalities in health outcomes and health access.

Clinical Psychologists could engage with South Asian grass-root organisations to facilitate conversations about ToP and reproductive health. Grass-root organisations can act as advocates for South Asian women and train clinical psychologists to deal with cultural and religious sensitivities. Clinical psychologists can filter this training down to clinical healthcare staff to

improve awareness of such issues.

Interventions need to be tailored to meet the needs of women (with sensitivity to the individual's religious and cultural beliefs) and where possible, these women should be worked with individually. This work needs to be done in a safe place, which allows women to organise and develop their thoughts and feelings about ToP and reproductive health away from patriarchy.

During the interviews South Asian women were unable to vocalise feelings that might be experienced by women (i.e. they spoke about challenges, struggles and hardship without fully acknowledging and expanding on these issues). Hence, it is unclear how much some women would be able to explore these issues within therapy, as it is in some women's belief system/ religious realm that for religious reasons women should not terminate (there was also challenges to this view). Attention would need to be given to the therapeutic relationship to foster trust. Clinical psychologists should provide the opportunity for South Asian women to vocalise challenges, struggles and hardship and help label some of the feelings experienced, and work together to form an idiosyncratic reading of the Qur'an (free from judgment) that is more in line with their 'being', with the aim of reducing cognitive dissonance, promoting critical thinking and increasing individual agency. In such circumstances it would be necessary to create a safe space, particularly when working with strong ideology when it conflicts with ideas, experiences and circumstances.

The confidentiality of psychological/counseling services needs to be highlighted to women to counteract the feelings of shame, fear, and judgment reported by participants. Also as previously mentioned the complexities of ethnic and religious group membership is complex hence, clinical psychologists need to be trained to deal with ethnic, religious and cultural sensitivities. It seems that clinicians (if interested) are responsible for seeking out literature and training opportunities exploring such issues. This can be problematic as research (Laird, de Marris & Barnes, 2007) indicates that there are shortcomings of medical literature accessed by clinicians, which imply that

'being an observant Muslim poses health risks, Muslims are negatively affected by tradition and should accept modernity and the "Islam" is a problem for biomedical healthcare delivery' (p.2425).

Clinical psychologists need to be able to support women who present in services with psychological health needs following a termination. It is unlikely that psychologists will have the same ethnic background and will be able to appreciate women's religious and cultural circumstances. Therefore, training psychologists to deal with cultural and religious sensitivities in an appropriate way is essential as this might enhance psychological recovery and improve health outcomes. Women will require psychologists to be non judgmental and may require reassurances of confidentiality.

It can be assumed that South Asian women would prefer to receive this information from someone of the same gender and it is worth asking if they would prefer a practitioner of similar ethnicity, religion and culture (if available). This study found that women tend to identify with certain groups and therefore they may feel understood whereas other ethnic groups were racialised and stereotyped. Similarly, women may prefer someone of the same gender because of difficulty openly challenging patriarchal views and the stigmatisation experienced. In addition, women spoke about traditional gender roles in South Asian family systems and therefore, women may fear being perceived as rejecting social and cultural norms of motherhood and marriage and religious views on this. During the interviews women did not challenge patriarchy instead some women witnessed coercion by men therefore, therapy might be hampered by gender. Existing studies suggest that South Asian women disliked seeing male doctors because of reasons including feeling embarrassed (Chapple, 2001). Given that ToP is a sensitive issue affecting females and is perceived as taboo subject and shameful practice it is likely that some South Asian may not feel comfortable talking about such issues with males particularly as women are discouraged from solitary interaction with men in some South Asian communities.

The findings of this study also highlight that options and information should be

widely available for women to access and that this information should be available in other languages.

There is a need to understand the conflicting norms experienced perhaps more commonly, with younger South Asian people. The norms and values present in the home and community environment may differ from the values of the wider community. Therefore, it is possible that South Asian people are likely to experience conflicting norms and messages. There may also be generational shifts in attitudes and beliefs as younger people may share the social norms of the wider community they are integrating. These are areas, which require further exploration.

It is unclear from the findings of this study how much sexual health knowledge South Asian women have. This is particularly significant because the rate for termination and previous terminations was the highest ever-recorded in 2009 for this ethnic group (DoH, 2009). Irrespective of sexual intercourse experience, there may also be a need for sexual health support for South Asians. It is possible that because issues pertaining to sexual health are perceived as taboo, support is not available or provided when required. Attention should be given to sexual health promotion and exploration of suitable strategies to engage with South Asian communities and the challenge is to deliver this in a 'culturally competent' manner.

It needs to be acknowledged that an inclusion criterion for women's involvement in the study was not dependent on whether they had previously had a termination. Therefore, the discourses women draw upon following a personal experience of a termination may vary, perhaps, illustrating some resistance to the religious and cultural discourses. Nevertheless, this study highlights the challenges South Asian women may face when considering or following a termination. In particular, the likelihood of limited social support being available and women experiencing emotional consequences as a result of the termination. Future research exploring whether women access support groups prior to or following a termination may be beneficial.

This study might have benefited from locating itself within a specific religious perspective. Islam is so diverse and exploring one school of thought i.e. scholastic traditionalism (as Muslim participants identified with these ideas) might have been more beneficial. Although the document analysis aimed to characterise the health and legislative discourses around terminations, participants did not identify with this. Therefore, perhaps the study would have been more informative if 'official discourses' (i.e. Shar'iah or influential interpretations of the Qur'an) for participants was considered. This study does however, offer value and indicates that essential principles of Islam are unanimously recognised.

An issue, which was not explored in the present study but may be pertinent, is generational differences in attitudes and behaviour. Participant referred to changing practices in sexual behaviour, which may reflect cultural assimilation where ethnic minorities assimilate into the 'dominant' culture where new customs and attitudes are acquired through contact and communication. Assimilation may involve a gradual change and take place in varying degrees and research exploring this issue may be advantageous.

Conclusions

Religious and ethnic identity plays a key role in South Asian women's efforts to make sense of ToP. Discourses prohibiting terminations and pre-marital sex were influential and provided meaning for Muslim women. Religious and ethnic group membership needs to be understood together with, degree of investment in a religious or ethnic identity. Such issues need to be addressed in healthcare practice, policy and research in order to begin tackling health inequalities in South Asian populations.

Clinical Psychologists need to liaise with grass-root organisations and develop religious and cultural competence through training to meet the needs of South Asian women. They also need to be willing to engage in discussion about religious, cultural and family influences on women's decision-making and practices. In addition, clinical psychologists need to help women identify sources of social support, as this is likely to reduce potential distress and

improve psychological health outcomes.

Reflections

During the research process I engaged in the process of reflection through using reflexive aids to maintain and enhance quality. Whilst attempting to be reflective throughout this paper I will now reflect on the various stages undertaken during this research process and excerpts of the extracts taken from my reflective diary will be shared.

Ethics, recruitment and interviews

This stage was time-consuming and at times exhausting. I was met with various obstacles, which I had to overcome fairly quickly.

I am feeling extremely frustrated! I have contacted all the community centres again and still no one has expressed an interest to take part. It has been three weeks and two days since the last interview. Some women did ask if they could do a telephone interview... I need to look into this. Also maybe I should look to recruit from outside the Nottinghamshire area. These changes would mean applying for ethics again...do I have time? I am so behind!

Later I eventually had some success with recruiting from outside the Nottinghamshire area and did not require the use of telephone interviews despite, applying again for ethics. I did wonder about women's reluctance at being interviewed about a controversial and sensitive subject matter. I felt that although the study may have the potential to upset some women it also offered the value of helping health professionals to understand the key influences on women's understandings and practices. Interestingly, Hutchinson and Wilson (1994) suggest that participant's experiences can be validated and patients can be empowered through them taking part in research. However, there was one woman in this study who did become upset when sharing her experiences, which led me to reflect on the ethics process.

The woman did become upset but I felt able to manage the situation. I understand that some people firmly hold the belief that terminations are wrong but then to have the experience of losing a child...must be devastating...she seemed ok though and wanted to continue with the interview.

The study had passed the University Ethics board therefore, I was aware of the protocol if participants did become distressed. My role as a trainee Clinical Psychologist allowed me to contain the situation and provide some support to the participant. The participant was also directed to alternative sources of support after the interview. This interview made me mindful of the distress the interview had the potential to cause and the importance of handling the interviews in a sensitive manner.

During some interviews I became aware of women referring to “our Islam” and using the term “you know”. Some women spoke about issues with the assumption that I had some shared lived experience and understanding. I was conscious about my own views on what participants spoke about and my characteristics in the meaning making process.

I wonder if participants think that I hold the same beliefs as them? Were they trying to get me on board with their perspectives? I feel that they wanted me to agree with them... it's difficult because I don't hold so 'extreme' views... but at the same time I don't want to come across as disagreeing with them as that would be invalidating... that's how they understand the issue and I have already explained that there's no right or wrong answer...I think I should keep trying to get participants to focus on their views...I have read that expressing naivety will encourage more comprehensive and detailed accounts.

I share similar characteristics as participants; I am South Asian, a woman and would describe myself as a Muslim. I wonder if participants think that I am a Muslim and if they do, how much influence this has in

what they say during the interview. I know I haven't told them but they might make assumptions from my name or even my interest in the area. It can be that they're not bothered whether I am or not....

Initially, I felt that participants might want to portray themselves as 'good' practicing Muslims during the interviews. However, on hindsight I felt that participants wanted to share what they felt was important to them and this was evident from the emotion expressed during the interviews. For example, some women spoke very passionately about their religious perspectives and the community they identified with. In addition, I felt women were quite open and honest in sharing their experiences. Perhaps my characteristics might have led participants to feel comfortable in the interview setting and not feel judged and misunderstood. I was cautious that because of these reasons participants might assume that I had lots of knowledge in the area. Therefore, where I did not understand something or there was space for interpretation I sought clarity, as I did not want to make assumptions on what participants had intended.

Analytic and theoretical issues

The most challenging part of the research process I found was the analysis. I spent months working and re-working my data. As there is no absolute way of doing Foucauldian discourse analysis I felt I had so much to learn particularly, about being able to apply the theoretical framework. I recall supervision sessions exploring models to use, some later being abandoned due to inappropriateness or not being feasible in the time-scale for the project.

Where do I begin? There just seems to be so much to get through... I feel like I'm going round in circles I feel lost with it all...I have spent weeks looking for a suitable way to do Foucauldian discourse analysis... the more I look at it the more confusing it seems... I need to go through everything and get some focus maybe a supervision session will help me think through my ideas and get some direction.

The framework for qualitative research adopted to evaluate its quality, (based on epistemology, methodology and method) was valuable during this process of confusion. Eventually I found a suitable model that would achieve what I had intended from the research. The transcription and analysis was begun immediately after the interviews and support was sought from supervisors with the aim of expanding the framework of reference. I found that the process of analysis was selective where I drew upon extracts to support the discourse. Therefore, an important part of the analysis was also to look for discontinuities or examples that challenged the claims made.

When I was interpreting the data I was mindful of my perspective of the construct 'ToP' and how my identity contributed to the constructions of meanings and my own assumptions of the world. Perhaps one way of checking my interpretation was to locate the research within a religious context, looking in detail at scriptural texts and doctrinal attitudes in an attempt to immerse and contextualise the ideas, beliefs and values and practices of Muslims.

Personal

I found it was crucial for me to adopt a theory of knowledge. As otherwise it would be impossible for me to engage in knowledge construction without at least tacit assumptions about what knowledge is and how it is constructed. I found that writing and reporting the findings were a crucial part of the analytic process and my thoughts developed when engaged in this process.

I was aware that I was inextricably involved in the whole research process, and therefore detailed records of my own participation, reactions and experiences was an extremely important data source during this process. I considered the power imbalance between participants and myself. I was aware that I was responsible to analyse and interpret participant's perspectives and therefore valued the data with respect and ensured I adhered to quality guidelines. At one point in the research I considered not using the data collected from the 'Indian' women and keeping the focus on Muslim women. However, I considered the woman offering her time and her

'voice' being missed out in the write-up of the study. Therefore, I felt it was important to ensure each participant was represented when writing up the study although I acknowledge that the focus in the journal paper is on Pakistani-Muslim participants.

This research has helped me to understand the valuable contribution of qualitative research whilst developing my own confidence in the use of qualitative methods. The audit trail and reflective diary was a valuable tool that encouraged thought and development. I also learnt that the research should be appropriately planned and managed and the impact on participants considered and the quality criteria adhered to.

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Appendix A: *Six major tendencies as described by Ramadan (2004)*

School of thought	Description
Scholastic traditionalism	<p>This tendency has attracted followers in the West and is found in various regions in the Muslim world. People who adhere to this view have a unique way of referring to scriptural Texts, the Qur'an and the Sunnah, characterised by a strict and sometimes even exclusive reference to one or other of the Schools of jurisprudence (the Hanafi, Maliki, Shafii, Hanbali, Zaydi, Jafari among others), therefore allowing no criticism of the legal opinions established in the school in question. The Qur'an and the Sunnah are references considered through the filter of the meaning and application stipulated by the recognised scholars of a given School. The scope for interpretation of texts is limited and does not allow development. Many trends, in one way or another, come under this mediated and scholastic approach to reading source texts. It is proposed that traditionalism insists on essential aspects of worship, on dress codes, and on rules for applying Islam that reply on the opinions of scholars. There is no room here for rereading, which are taken to be baseless and unacceptable liberties and modernisations. These communities are primarily concerned with religious practice and in the West do not envisage social, civil, or political involvement. Their reading of texts and the priority they give to the protection of strict traditional practice makes them uninterested in and even rejecting of any connection with the Western social milieu, in which they simply cannot conceive that they have any way of participating. The discourse they propound and the education that they provide are based on a religious foundation perceived through the prism of their traditional reading of the legal principles on a given or recognised</p>

	school.
Salafi Literalism	<p>In contrast with the scholastic traditionalists, the salafi literalists reject the mediation of the juridical schools and their scholars when it comes to approaching and reading texts. The Qur'an and the Sunnah are interpreted in an immediate way without scholarly councils. The literalistic character of this approach gives this trend an equally traditionalistic character that insists on reference to the texts but forbids any interpretive reading.</p> <p>The salafis insist, in all circumstances, on the necessity of reference to and on the authenticity of the Texts quoted to justify a certain attitude or action, whether in the area of religious practice, dress code, or social behaviour. Only the text in its literal form has constraining force, and it cannot be subjected to interpretations that, by definition, must contain error or innovation.</p> <p>The relationship of the salafis with the social environment is characterised primarily by isolation and by a literally applied religious practice protected from Western cultural influences.</p>
Salafi Reformism	<p>This tendency share with salafi literalists a concern to bypass the boundaries marked out by the juridical Schools in order to rediscover the pristine energy of an unmediated reading of the Qur'an and the Sunnah. In contrast with the literalists, although the Texts remain for them unavoidable, their approach is to adopt a reading based on the purposes and intentions of the law and jurisprudence (fiqh).</p> <p>Most groups within the salafi reformist trend grew out of the influence of reformist thinkers who have a very dynamic relation to the scriptural sources and a constant desire to use reason in the treatment of the Texts in order to deal with the new challenges of their age and the social, economic and</p>

	<p>political evolution of societies. The aim is to protect the Muslim identity and religious practice, to recognise the Western constitutional structure, to become involved as a citizen at the social level, and to live with true loyalty to the country to which one belongs. Salafi reformism thought is widespread in the West, and a large number of associations are influenced by the way of reading the Texts, which they adopted and adapt in keeping with their needs and actions.</p>
<p>Political Literalistic Salafism</p>	<p>This trend was essentially born of the repression that has ravaged the Muslim world. Scholars and intellectuals originally attached to the legalistic reformist school went over to strictly political activism (while they were still based in the Muslim world). All they retained of reformism was the idea of social and political action, which they wedded to a literalistic reading of Texts with a political connotation concerning the management of power, the caliphate, authority, law and so on. The whole constitutes a complex blend that trends towards radical revolutionary action: it is about opposing the ruling powers, even in the West, and struggling for the institution of the 'Islamic state' in the form of the caliphate. The discourse is trenchant, politicised, radical and opposed to any idea of involvement or collaboration with Western societies, which is seen as akin to open treason.</p>
<p>'Liberal' or 'Rationalistic' Reformism</p>	<p>Essentially born out of the influence of Western thought during the colonial period, the reformist school has supported the application in the Muslim world of the social and political system that resulted from the process of secularisation in Europe. In the West supporters of liberal reformism preach the integration/ assimilation of Muslims,</p>

	<p>from whom they expect a complete adaptation to the Western way of life. They do not insist on the daily practice of religion and hold essentially only to its spiritual dimension, lived on an individual and private basis, or else the maintenance of an attachment to the culture of origin.</p> <p>The majority of liberals are opposed to any display of distinctive clothing that might be synonymous with seclusion or even fundamentalism. With social evolution in mind, they believe that the Qur'an and the Sunnah cannot be the point of reference when it comes to norms of behaviour and that it is applied reason that must now set the criteria for social conduct.</p>
Sufism	<p>The Sufi trend is numerous and very diversified. Sufi circles are essentially orientated towards the spiritual life and mystical experiences. They do have community and social involvement but it is their matter of priorities, which are determined differently: the scriptural Texts have a deep meaning that, according to Sufi teachings, requires time for meditation and understanding. There is a call to the inner life, away from disturbance and disharmony. Here the text is the ultimate point of reference, because it is the way to remembrance and nearness: it is the only path to the experience of closeness to God.</p>

Appendix B - University ethical application correspondence

Below I have detailed my email correspondence with Emile van der Zee (Lincoln University Ethics board) who granted ethical approval for this study.

From: Rajea S Begum (10166639)

Sent: Fri 29/10/2010 10:17

To: Emile van der Zee

Subject: RE: ethics

Dear Dr Emile van der Zee,

Please find attached the university ethics form and supporting information related to my research.

I would be grateful if you are able to confirm receipt and give me some indication of how long the process of obtaining ethics from the university will take.

Rajea Begum

Trainee Clinical Psychologist

Doctorate in Clinical Psychology

From: Emile van der Zee

Sent: Wed 17/11/2010 11.44

To: Emile van der Zee

Subject: RE: ethics

Dear Rajea,

Here are the issues that were raised by the Ethics Committee about your proposal:

Seeing your proposal would have been helpful; e.g., there is no literature cited at all - this gives the idea that the project is not grounded in current debates or research.

We assume that you will not approach NHS facilities. Otherwise NHS approval would be required. The project has the potential to bring the interviewer at risk. The project is about a controversial issue in the Asian

Community. Although the interviewer may not be at risk from the interviewee, there is a risk from other people being present if the interview is carried out in the home environment. We would strongly encourage you to consider interviewing at the University, or other premises, but not at people's homes. A limit to data withdrawal should be provided. E.g., people cannot withdraw any data after write up/publication.

Where will names and postal addresses be stored? Occupation and relationship status did not seem to be part of the research. Why ask for it? Please do not provide your own mobile phone number. Use a University phone. With a sample qualitative sample exploring age-generational differences not possible. How do you intend to analyse the interviews? Who is your supervisor?

*I'm looking forward to your reply. Could reply by e-mail saying how you addressed each issue separately, and could you adjust the application papers accordingly and attach these as well. If you have any questions about the comments, please let me know asap. Many thanks,
Emile*

From: Rajea S Begum (10166639)

Sent: Fri 26/11/2010 14:51

To: Emile van der Zee

Subject: RE: ethics

Dear Emile,

Thank you for you email.

In response to you questions:

- 1) I have attached my project proposal*
- 2) I an not recruiting from NHS facilities*
- 3) I will interview at the community centre which participants access or at the university (I have made the amendments- please see appendices)*
- 4) Please see consent form where I have made it clear that participants cannot withdraw the data after the write-up.*
- 5) I have made reference to where names and postal addresses will be stored*

(locked, secure cabinet at the university of lincoln)

6) I am asking for occupation and relationship status to be able to describe the sample and it is commonly asked for in qualitative research, I have also discussed this with my supervisor)

7) I have removed my mobile number and I am currently awaiting a mobile from the university to use for research purposes

8) I understand that exploring generational effects may not be possible however; this is not an explicit variable. If I did get participants from different generations then this would be great but my research is not dependent on this.

9) I intend to use Foucauldian discourse analysis to analyse the interviews

*10) My supervisor is Roshan das Nair at The University of Nottingham
I have amended the application papers according to your feedback and have also attached these.*

I hope I have answered all your questions.

Look forward to hearing from you soon.

Best wishes

Rajea

From: Emile van der Zee

Sent: Tues 30/11/2010 11:11

To: Emile van der Zee

Subject: RE: ethics

Dear Rajea, this is to confirm that you have ethical approval for your project, on the condition that proper after care is provided for those who have been interviewed and may be upset about the contents of the things discussed.

Good luck with your project, all my best,

Emile

From: Rajea S Begum

Sent: Tue 01/04/2011 11:26

To: Rajea S Begum (10166639)

Subject: RE: ethics

Dear Emile van der Zee,

I was granted ethical approval sometime ago from the University ethics board. Since then I have encountered many difficulties with recruitment. Following discussion with my thesis supervisor (Roshan das Nair) I am therefore proposing the following amendments:

1) Use of telephone interviews 2) Recruiting from the UK (as opposed to just the Nottingham area)

Whilst recruiting women have expressed reluctance to take part and several women have stated that they will take part in the research if the interview is conducted over telephone. The reasons for this include: not feeling comfortable doing face-to-face interviews, travelling to the University, not happy doing the interview at community centres where others may know them, only being available in the evening due to working hours and young children.

Therefore, I feel women may feel more comfortable talking and opening up about sensitive topics over the phone rather than face-to-face with a stranger. This method will allow for recruitment of South Asian from across the UK, cutting financial and time costs for both women and myself and being restricted to recruiting just from the Nottingham area.

Telephone interviews lent themselves well to be conducted in the evenings, which was the preference of women I have spoken with, in comparison to face-to-face interviews where either researcher or interviewee may have to travel long distances. Women work and some have young children, they were often restricted as to the times at which they could complete the interview. Telephone interviews will allow me to be flexible and complete interviews at any time of day or in the evening. This flexibility may potentially facilitate recruitment.

Telephone interviews had certain advantages for the purposes of recruitment, financial and time costs for this study. Although, telephone interviews may be criticised for not picking up on subtleties of body language and facial expressions conveying further information and emotions as face-to-face interviews do. Studies have found little difference between the quality of data from face-to-face and telephone interviews (Aneshensel, Frerichs, Clark & Yokopenic, 1982; Rhode, Lewinsohn & Seeley, 1997) and face-to-face

interviews may bias respondents to give more socially acceptable answers in comparison to similar questions asked over the telephone (Colombotos, 1969). It is possible that women may feel more comfortable and less inhibited to discuss events and emotions over the telephone.

I will look forward to hearing from you soon.

Best wishes

Rajea Begum

Trainee Clinical Psychologist

From: Emile van der Zee

Sent: Tue 05/04/2011 12:38

To: Rajea S Begum (10166639)

Subject: RE: ethics

Dear Rajea, as it happened I was just going through your e-mail, and old application.

You would need to modify the old application to implement the changes you suggest, and also show how you address the original issues in this new context, but also how you address new issues: e.g., (1) how do you get the phone numbers for the people you want to approach, (2) how do you deal with people who can be upset. I'll then have a look, and make a judgment of whether it has to go through the committee again, or whether I deal with it by chair's action. All my best, Emile

From: Rajea S Begum (10166639)

Sent: Mon 18/04/2011 12:43

To: Emile van der Zee

Subject: RE: ethics

Dear Emile,

I have had some success with recruitment. Therefore I will not require the use

of telephone interviews however, I will need to recruit from outside the Nottinghamshire area namely South Yorkshire as I have a contact in a community centre there and I am hoping to recruit women from there. In terms of my ethics application this is the only amendment and I wondered if this would be ok. Again all the protocol is the same as specified earlier. Please find attached with the addition of South Yorkshire highlighted in red.

Thank you, Rajea

From: Emile van der Zee

Sent: Thurs 05/05/2011 10:38

To: Rajea S Begum (10166639)

Subject: RE: ethics

Hi Rajea, this is not a problem at all. Good luck with your study, all my best,

Emile

Appendix C: letter to organisations (version 2)



Trent Doctorate in Clinical Psychology



Faculty of Health, Life & Social Sciences

University of Lincoln
1st Floor, Bridge House
Brayford Pool
Lincoln
LN6 7TS
T: 01522 886 029
F: 01522 837 390
Email:
10166639@students.lincoln.ac.uk
Mobile: 07519357391

Institute of Work, Health & Organisations

University of Nottingham
International House, B Floor
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB
T: 0115 846 7523
F: 0115 846 6625

South Asian women's understanding and views of abortion

Dear XXX,

As discussed during my recent telephone conversation with you, I am currently undertaking some research as part of my doctoral thesis and wondered if I could request your help in recruiting South Asian women to my study from your organisation.

The purpose of my research is to explore how South Asian women understand, think, and talk about abortion. Participation in this research would involve an individual interview with me lasting approximately one hour on this topic.

I feel such work is valuable as the findings may provide an important contribution to research in this area and may develop our understanding of the challenges South Asian women face when considering an abortion, and the distress they may experience during this process. Understanding the emotional impact of this process may also offer an important contribution to

public health and be useful in informing and developing support services for women in general, with an awareness of the needs of South Asian women.

I would be very grateful if you would allow me to display posters at the centre and give out information about the research to South Asian women who access services at this centre (please see material enclosed). If you have any additional questions please do not hesitate to contact me. I am also happy to come to the centre and talk about the research and answer any additional questions you or anyone else may have.

Thank you for all your help.

Yours sincerely,

Rajea Begum
Trainee Clinical Psychologist

Appendix D: participant information sheet: 10/10/2010 (version 4)



Trent Doctorate in Clinical Psychology



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F: 0115 846 6625

Information about the research

South Asian women's understanding and views of abortion

Hello, my name is Rajea. I am a British South Asian woman who is interested in undertaking research with South Asian women to understand their views and feelings towards abortion.

I am a trainee Clinical Psychologist currently undertaking doctoral training at The University of Lincoln and The University of Nottingham. I am hoping to get women involved in my research and I would like to invite you to take part. If after reading this information you are interested in taking part in my research then please get in touch.

1. What the research and your participation involves

If you decide you would like to be involved in my research then this will involve an interview with me that will last approximately one hour. This interview will cover issues such as your understanding of abortion, any experiences you or anyone you know may have of abortion and would like to share, and your thoughts about abortion in general.

I will arrange a meeting with you before the interview, which will last up to one hour. This will give us the opportunity to meet and for you to ask any questions and discuss any issues relating to this research. I will also give you a consent form to read and sign if you agree to take part. All the data obtained and everything that you say during the research will remain strictly confidential.

There will be an audio recording of the interview to keep an accurate record of what is said. Please be assured that any data produced during the interview will be coded and transcribed so you will not be personally identifiable. When analysing the data from the interviews transcribers will be employed. They will be required to sign a confidentiality agreement to ensure that your identity remains protected and the data produced from the interviews remains confidential. Interview data and any original identifiable data will be safely locked away at The University of Lincoln.

2. Who is being asked to get involved?

I am keen to speak to women from all backgrounds who are above 18 years of age, who read and speak English and self-define their ethnicity as South Asian (Bangladeshi, Indian or Pakistani).

3. How to get involved

If you are interested in getting involved then I would be delighted to hear from you. My contact details are printed at the bottom of this leaflet, along with some common questions people ask about my research. When you contact me I will arrange a meeting with you to discuss the research and I am happy to answer any further questions that you may have.

4. Reasons for the research

The aim of conducting this research is to explore the ideas South Asian women have about abortion, particularly the role of culture and religion and the influence of family and friends on women's views of abortion. You do not need to have had an abortion in order to take part in this research.

Your views are valuable as these issues affect many women in different circumstances. I feel that a better understanding of women's feelings and attitudes of abortion will be very useful and may have an impact on future services and help educate health professionals about the needs that South Asian women may have.

5. How will the information be used?

I will use direct quotes from what is said during the interviews to contribute to my doctoral thesis to illustrate a point and support my ideas. These quotes will be anonymous so no one will know what you have said.

6. Potential discomforts

Abortion is a sensitive area and may cause distress to some individuals. The researcher will stop the interview if you become significantly distressed and any data accumulated will be destroyed and safely disposed of. Alternatively, you can stop the interview or choose not to answer questions, which you are uncomfortable with. An explanation will not be required and there will not be consequences of any kind. After the interview you will be provided with some contact telephone numbers of support services should you wish to talk to anyone about the issues raised.

7. Some questions which you might have

Q. Who is being asked to participate?

A. Women from a South Asian background, who are above 18 years of age and who read and speak English

Q. What if I don't know much about abortion?

A. I want to talk to women with all levels of knowledge. Don't worry about giving the 'wrong' answers there are no right or wrong answers

Q. What if I don't agree with abortion?

A. I am still interested in talking to you as your views and opinions are of equal relevance to my research

Q. What if I don't want to share any personal experiences?

A. Don't worry you won't have to, simply talk about what you are comfortable with

Q. Will you tell other people what I say?

A. No. All discussions will be strictly confidential and you will not be personally identified

It is up to you whether you wish to take part in the research. If you do decide to take part you are free to withdraw from the research at any time, without giving a reason up until the write-up of the research. I will reimburse your travel expenses (maximum of £10), if you provide receipts of travel. The interviews will be conducted at the University of Nottingham or the community centre that you attend, if this is a place more convenient for you.

Remember you don't need to have had an abortion in order to take part in this study- I am only interested in your views

South Asian women's understanding and views on abortion

Doctorate in Clinical Psychology research project

For further details please contact:

Rajea Begum (researcher)

Faculty of Health, Life and Social Sciences.

The University of Lincoln,

1st Floor, Bridge House

Brayford Pool

Lincoln LN6 7TS

E-mail: 10166639@students.lincoln.ac.uk

Telephone: 07519357391

(to minimise your costs I am happy to call you back)

Appendix E: posters displayed in community centres



Trent Doctorate in Clinical
Psychology research project



Participants needed for research study exploring:

SOUTH ASIAN WOMENS UNDERSTANDING AND VIEWS OF ABORTION

I am looking for volunteers to take part in a study exploring South Asian women's views

As a participant in this study, you would be asked to take part in an interview lasting up to one hour

All discussions will be strictly confidential and you will not be personally identified. **Remember you don't need to have had an abortion in order to take part in this study- I am only interested in your views**

For more information about this study, or to volunteer to take part in this study please contact:

Rajea Begum (researcher)

Faculty of Health, Life and Social Sciences.

The University of Lincoln,

1st Floor, Bridge House

Brayford Pool

Lincoln LN6 7TS

E-mail: 10166639@students.lincoln.ac.uk

Telephone: 07519357391

(to minimise your costs I am happy to call you back)

This study has been reviewed by, and received ethics clearance through, The University of Lincoln

Appendix F: Demographic data sheet (version 2)

Demographic Data Sheet

Please specify by either writing your response or marking/ticking the appropriate box. I am collecting this data to simply describe the people taking part in the study and you will not be personally identifiable to others. Thank you for providing this information.

Age

--

Relationship Status

Married/ Civil partnership	
Divorced/ Separated	
Single	
Co-habiting	
Widowed	

Motherhood

Children	
No children	

Ethnicity

Bangladeshi	
Indian	
Pakistani	

Religious Views

Buddhist	
Christian	
Hindu	
Muslim	
Sikh	
None	
Other (please specify)	

Occupation

Employed	
Unemployed	
Student	
Other (please specify)	

In which country were you born?

In which country were your parents born?

Which country did your grandparents originate from?

Is English your first language?

Yes

No

<input type="text"/>	<input type="text"/>
----------------------	----------------------

If not, what is your first language?

Appendix G: consent form for participants (version 3)



Trent Doctorate in Clinical Psychology



The University of
Nottingham

Faculty of Health, Life & Social Sciences

University of Lincoln
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T: 01522 886 029

F: 01522 837 390

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Mobile: 07519357391

Institute of Work, Health & Organisations

University of Nottingham
International House, B Floor
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

T: 0115 846 7523

F: 0115 846 6625

CONSENT TO PARTICIPATE IN RESEARCH

South Asian women's understanding and views of abortion

By signing this form you are agreeing to participate in a research study conducted by myself, Rajea Begum (Trainee Clinical Psychologist), from the Faculty of Health, Life and Social Sciences at the University of Lincoln.

Please initial box

1. I confirm that I have read and understand the information sheet dated 10/10/2010 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and there will be no consequences of any kind

☐

3. I agree to the interview being audio-taped ☐

4. I agree to take part in the above study ☐

5. I understand that I cannot withdraw the data accumulated from the interview after the write-up of the research ☐

Name of participant:

Date:

Signature:

Name of person obtaining consent:

Date:

Signature:

The findings of the research will be available for you once the doctoral thesis has been completed in 2012/ 2013. If you are interested and would like me to send you a summary report of the findings please specify this below.

I would like to be provided with the findings of this study

YES

NO

☐☐

If yes, please provide a postal or email address

.....
.....
.....

Please be assured that the information provided and interview data will be safely locked away at the University of Lincoln.

Thank you

Appendix H: Interview protocol (version 3)

Interview Protocol

South Asian women's understanding and views of abortion

General interview schedule for the interview

Thank you for volunteering your time to take part in this interview, it is very much appreciated.

- Cover confidentiality: Just to clarify, everything that you discuss in this interview is confidential between you, and me. This recording will be transcribed and assigned a code. Therefore you will not be identifiable from the transcript. Do you have any questions about confidentiality and storage of data, which were not answered by the information sheet?
- Refresh what will happen: It is expected that this interview will last for no longer than 50-60 minutes. Feel free to suggest something that you would like to talk about if you think there is something important we have not covered. I am interested in your views on ToP therefore I would welcome your comments even if these go beyond the questions in the interview schedule. These questions are only used to provide some structure to this discussion.
- Do you have any questions before we start?

Before we begin do you have any questions?

1) ***Understanding of abortion***- What do you know about abortion?

Prompts:

- Services/ procedures
- Pre-natal screening for genetic conditions
- Voluntary choice

2) ***Views on abortion***- How do you feel about abortion?

(I.e. whether they agree or disagree)

Prompts:

- Attitudes
- Feelings
- Beliefs

- 3) **Culture-** Would you be able to tell me about how abortion may be understood in your culture/ community you live in?

Prompts:

- Social and cultural norms and understandings

Do your own beliefs differ from these? (In what way?)

- 4) **Religion-** Do you follow a religion? (*If yes*) Does your religion have a view on abortion?

Prompts:

- Participants religious view (does this influence their attitude towards abortion or not)

- 5) **Decision-making-** If a friend was considering having an abortion what factors do you think would influence her decision to have an abortion or not?

Prompts

- Reactions and opinions of others (family/f friends/ partner)
- Stability of relationship/ absence of relationship
- Financial status
- Career/ education
- Age
- Preference not to have anymore children
- Risk of having a child with a serious genetic condition/ disability

- 6) ***Information about abortion-*** Where would your friend be likely to go to get advice about an abortion and whom would she feel comfortable talking to?

Prompts

- Reliable sources
- Family/ friends

Anything else – We have now covered all the areas that I specifically wanted to talk about, is there anything else that you would like to add?

Ending the interview

- Thank you for taking the time to take part in this study. If you have any questions or concerns after I have left then please contact me. Abortion is a sensitive topic, which may upset some people therefore I am going to give you a number you can phone should you require any support.
- It is expected that this study will be completed in September 2012. I plan to email/ post participants who have expressed an interest in the findings with a summary report of the findings

The end

APPENDIX I: *adapted Jeffersonian transcription notation system*

Symbol	Example	Explanation
(.)	that is (.) upsetting?	Short untimed pause
_____	I <u>know</u> that	Underlining indicates speaker's emphasis or stress.
{	T: {Well at's R: {I mean really	Left brackets indicate the point at which one speaker overlaps another's talk.
WORD	That is WRONG	Capitals, except at beginnings, indicate a marked rise in volume compared to surrounding talk.
.	Yeah.	Full stop indicates falling intonation.
(())	I don't know ((laughs))	Words in double parentheses contain author's descriptions.

(Taken from Rapley, 2007, p. 60)